Maternal and Child Health Services
Title V Block Grant

State Narrative for Kentucky

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications for the Title V, Maternal and Child Health Block Grant are on file in the office of the Division of Adult and Child Health Improvement. 502-564-4830.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input for the Title V Block Grant is accomplished in several ways.

The Department for Public Health submits two copies of the Title V/Maternal and Child Health Block Grant application to the Legislative Research Commission (LRC) of the Kentucky General Assembly. After the grant submission each July, DPH presents testimony about the Block Grant to the Health & Welfare legislative committee each year before they approve the grant.

A public hearing is scheduled annually for the DPH block grants, during July, prior to submission of the application. Information about the Title V Application process, overview of the purpose and data compared over multiple years is provided. A news release is sent from the CHFS Office of Communications to media within the state announcing the date and location of the public hearing. Title V staff are in attendance and are available for questions at each hearing. However, this is not the process through which the Title V Program obtains most of the public input.

A link to the Title V/Maternal and Child Health Block Grant is on the Department for Public Health Website.

/2010/ The Commission for Children with Special Health Care Needs values public input concerning the children and youth with special health care needs (CYSHCN) population, utilizing contributions to enhance and develop new programs for CYSHCN.

The Parent Advisory Committee (PAC) and Youth Advisory Committees (YAC) are open to all parents and children of CYSHCN. Both committees participate in program development, planning, and implementation. In 2008, the PAC reviewed the exit process and suggested improvements. They also participated in the Region 4 Genetic Collaborative by recruiting families to serve on the transition, medical home and care coordination teams. Members of PAC and YAC provided input in support of the anti-bullying bill, HB 91. In 2009, members participated in the development of the family survey, which will be used for the Needs Assessment for CYSHCN.

The Commission ensures public input on program development by including parents on the Board of Commissioners, the Hemophilia Advisory Committee, and the Early Hearing Detection and Intervention Advisory Board. These groups meet annually, receiving regular updates and working with the Commission on committees or workgroups throughout the year. Information about the Block Grant performance measures are shared with these groups.

The Commission participates in many organizations, workgroups and committees across the state. Staff is involved with transition/family exhibit information fairs, job/transition fairs, health fairs, school fairs, the annual State Fair, and Disability Mentoring Day activities. The Transition Administrator is the Chair of the Statewide Council for Vocational Rehabilitation and on the Board of Directors for the Center for Accessible Living. A parent consultant is currently the State Coordinator for the Kentucky chapter of Family Voices and serves on the Kentucky Council on Developmental Disability.

The Commission's website provides information on the Needs Assessment and agency services. Contact information is available on the website at http://chfs.ky.gov/ccshcn/default.htm. Materials are available in English and Spanish (and other languages, as needed), and every attempt is made to provide a third grade education literacy level. The agency operates a consumer call line for members of the public who would like to call and voice thoughts and concerns on a variety of matters. A voice mail box with a Spanish greeting is available. The Commission utilizes a language call line for third party interpretation.

The Commission employs 7 nurse consultants within the Foster Care Support Branch who work with caregivers of CYSHCN in the child welfare system to continuously assess this special area of public need.

Understanding that younger generations have different expectations about access to services, the Commission will broaden its scope of public input by drawing on web-based tools, such as Facebook, Twitter, Blogs, and the Commission website. The Commission is seeking new, efficient methods of reaching the public through the Family to Family grant.

DPH conducted 11 forums throughout the state in March -- May of 2009 that were attended by over 500 interested stakeholders, including LHD directors, CHFS partners, contractors, and providers. The forums covered many topics that were of interest to stakeholders since they had been identified by them through a web-based survey conducted prior to the forums. DPH distributed surveys in health care settings in order to hear the voice of clients who are being provided services under Title V Block Grant. Surveys were available in English and Spanish. We received 3,200 completed surveys from patients that are currently being analyzed.

DPH distributes other surveys on a continuing basis in order to receive input from the populations served. The HANDS Parent Satisfaction survey is distributed annually in March; the most recent analyzed was distributed in March, 2007 to those families who had participated in HANDS services for at least six (6) months, including those who had exited, during the past year. 117 out of 120 counties were represented, with a 29% response rate to the 4524 surveys that were distributed. Of all surveys received, responses averaged good or excellent for enrollment, interview processes, and quality of services.

First Steps surveys are mailed out annually in July to elicit information from parents reporting if they are being helped by the program, if families know their rights, and if families can effectively communicate their children's needs and help them develop and learn. In 2008 all responses received were 79% and above affirming these issues. In 2009 approximately 8,200 were mailed out but not all responses are back yet.

The First Steps Interagency Coordinating Council includes parent representatives and receives input from the public during quarterly meetings. From this input, the council makes recommendations on any part of early intervention services.

The Interim Joint Committee on Health and Welfare held a public hearing on Tuesday, July 14, 2009. A brief overview of the MCH grant programs and services was given by the grant administrative official. The hearing was attended by one legislative representative and two students from the University of Kentucky. There were no questions or comments received. //2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

In 2006, based on Kentucky's rising rate of preterm birth, the Division of Maternal and Child Health analyzed data related to prematurity. We compared our preterm birth rate with several surrounding states and found we had the highest preterm birth rate of any of our contiguous states. Analysis of our birth certificate data included such factors as medical risk conditions, age of mother, births from assisted reproductive technology, multiples, C-section and vaginal deliveries by gestational age. This analysis identified the late preterm infant as the primary factor in our rising preterm birth rate. This analysis was one of the factors which led to our selection for the prematurity prevention initiative "Healthy Babies are Worth the Wait" with National March of Dimes and Johnson & Johnson (Corporate contributions division) as partners.

In 2007 (2008 Title V application), State Performance Measures were deleted or revised for clarity and to assist Kentucky to concentrate fully on our goals of improvement. For FY 2008, Kentucky has deleted 2 State Performance Measures (#3 and #6) due to their similarity to National Performance Measures. Another State Performance Measure (#5), "Decrease the rate of Birth Defect Specific Infant Mortality in Kentucky" was also deleted because any new progress would be difficult to measure. Deleting these Performance Measures allows Kentucky to provide a renewed and sharpened focus to the National Performance Measures and the remaining State Performance Measures. State Performance Measure #4 was revised to focus on Medicaid eligible pregnant women and the oral health care they receive during pregnancy. Medicaid eligible children and oral health is the focus of Health Systems Capacity Indicator #7B. State Performance Measure #7 was revised to address preconceptual services for all women of child-bearing age.

In 2008, Kentucky requested and received Technical Assistance regarding Needs Assessment from MCHB to begin planning for the 2010 Needs Assessment. A Title V Needs Assessment Technical Assistance Meeting was held on March 24, 2008 led by the team from the University of Chicago, College of Public Health: Michelle Issel, Deb Rosenberg, Arden Handler, and Joan Kennelly.
This TA provided an overview of needs assessment elements, a review of process models, examples of other states with good processes, and a discussion of Kentucky's capacity and issues. An action plan was developed which included a logic model and timeline. Based on this TA, planning for the comprehensive 2010 needs assessment is underway and will include both qualitative and quantative data, from existing sources and new sources of information. The goal is to identify needs from the level of communities as well as the overall state picture.

In 2009, the MCH Division began the process by electronically surveying stakeholders and distribution lists of people with current ties to state programs. Over 1100 responses were received. An executive summary of the web-based survey is attached. From this initial data, topics were selected for a series of state-wide community forums. These forums were conducted March-May 2009 in 11 sites across the state. Data collected is currently being analyzed for recurring themes. The plan is to develop quantative information/fact sheets and follow with presentations to stakeholder groups. Priorities will then be developed based on a prioritization matrix. Following the prioritization, the state-specific performance measures will be developed.

An attachment is included in this section.

III. State Overview
A. Overview
III. STATE OVERVIEW

A. OVERVIEW

Geographic

The Commonwealth of Kentucky is a diverse state geographically, with fertile fields in the West supporting agriculture, the Appalachian Mountain Range in the East providing jobs in the lumber and coal industries, and the Bluegrass or Central region of the state, renowned for its thoroughbred horse industry. There are two major cities, Louisville and Lexington, both with major universities, the University of Louisville and the University of Kentucky. Each of these schools has a medical and dental school, schools of public health, research activities, and teaching facilities that support public health initiatives. These universities are also affiliated with the two major tertiary care hospitals providing specialized services. A third medical school, the Pikeville School of Osteopathic Medicine, is located in far eastern Pike County. Other universities with Schools of Public Health include Eastern Kentucky University (Richmond), and Western Kentucky University (Bowling Green). Eastern Kentucky University is more focused on Environmental Health and Community Health Education. Other Universities are supportive of Public Health including Kentucky State University (Frankfort) and Northern Kentucky University in Ft. Mitchell, Kentucky.

Kentucky has 120 counties varying in geographic size, population, income/poverty and educational attainment. These range from the small Eastern Kentucky county of Robertson (pop. 2,266 in 2000) to Jefferson County (pop. 693,604 in 2000). Key areas remain isolated and distant from major cities, universities and health care services. The Eastern Kentucky Coal Field is the primary region falling into this category. Due to the mountainous areas with winding and narrow roads, residents may drive several hours to reach a main interstate artery.

The far eastern portion of the state consists of 51 counties that are a portion of the Appalachian region. Compared to other areas of the state, residents in eastern KY have lower income and education levels and have higher rates of many health problems. The Appalachian population is approximately 1,145,000 and is dispersed over 17,714 square miles. Nearly 70% of Appalachians live at or below the federal poverty level. Additionally, only 62% of adults in Appalachia have completed high school, compared to the statewide average of 74%, and the national average of 80.4%. In 2004, the Appalachian Regional Commission reported that Appalachians as a minority group are characterized by significantly high rates of poverty, substandard housing, high unemployment rates, and discriminatory attitudes about their culture. Many of these areas have a shortage of health care professionals, resulting in little or no access to primary health care and a heavy reliance on regional hospitals and medical clinics. Because of the small populations in many counties, county-specific health data is difficult to obtain and may have questionable accuracy when available. This means that regional data is often the only information available to health professionals planning interventions and assessing need. /2009/ The planned National Children's Study has NO sites in the 51 county Appalachian region, so needed data for this high-risk area will not be collected from that study. //2009//

Demographic

Kentucky's total population is estimated to be 4,205,648 according to 2005-2007 American Community Survey Demographic and Housing Estimates (U.S. Census) with a median age of 37.3 years, just slightly older than the U.S. median of 36.4. The population of Kentucky is estimated to have increased by 163,879 individuals since the 2000 Census. This places Kentucky 26th among states in population in (U.S. Census, 2008). Kentucky's rate of live births has also steadily increased, from 54,492 in 1999 to 55,990 in 2005, an increase of 3%. The racial breakdown for Kentucky is estimated to be 90.4% white, 8.1% African American, 1.2% Asian and

<1% American Indian/Alaskan Native (American Community Survey 2005-2007).

In the Louisville/Jefferson County area, Kentucky's largest urban area, this population is estimated to be 20% of the total county population (for 138,856 citizens) in 2005-2007. This number of individuals represented approximately 44% of the entire African-American population in the Commonwealth of Kentucky. Other counties with substantial African-American populations (as a portion of the total population in the county) in 2005-2007 include Christian (22.7%), Fayette (14%), Hardin (11.4%) and Warren (8.7%) (American Community Survey 2005-2007 Demographic and Housing Estimates, 2005-2007).

2000 Census data revealed that the Hispanic population in Kentucky was growing rapidly, with an increase of 172.6 % over 1990 Census totals. The Hispanic population nearly tripled from 20,363 in 1990 to 59,939 in 2000. This figure, of course, does not take the non-citizen population into account, which is thought to be a substantial number.

/2010/ Births in Kentucky in 2007 total 58,959, which is a 1.7% increase from 2006. The African American population remains stable at about 7.7% of Kentucky's total population. Based on population estimates from 2007, the Hispanic population in Kentucky is 94,626, which is an increase of 9.2% from the previous year. For 2007, the counties with the highest Hispanic populations are: Jefferson (20,845), Fayette (15,531), Christian (4,288), Warren (3,871), and Hardin (3,664). Total Hispanic females in 2007 in Kentucky are estimated to be 40,895 and 1,189 are infants. //2010//

Patient data for children enrolled in the Commission for Children with Special Health Care Needs reflects the growing Hispanic population and comparatively low numbers of other immigrant populations. A data snapshot of the Commission's population taken on June 30, 2006 showed the following distributions among the 8,862 active enrollees, 78% white; 8.2% Black/African American; 4% Hispanic; 3% Other; less than 1% Asian, less than 1% Native American/Alaska native and less than 1% Native Hawaiian/Pacific Islander. Of these same 8,862 active enrollees, 8,472 listed English as their preferred language and 256 individuals listed Spanish as the next highest preferred language. Sign language continues to rank third, Bosnian 4th. Other language preferences include Albanian, French, German, Russian, Somolian, etc. CCSHCN is experiencing an increase in the percentage of Hispanic clients.

Socioeconomic Indicators

Socioeconomic indicators for Kentucky's population vary widely. A few of the key indicators are reviewed below for Kentucky. Data is supplied by 2004 County Health Profiles, produced by the Kentucky State Center for Health Statistics, Kentucky Department for Public Health.

Rates of Medicaid Eligibility and Use: In 2004, 20.6% of the population of Kentucky was Medicaid eligible. Statewide, of the 20.6% eligible for Medicaid, only 19% of those individuals actually used Medicaid services.

Food Stamp, AFDC, and WIC Recipients: These measures present data on the proportions of the population who accessed programs for the indigent. In fiscal year 2004, 13.3% of the total population received food stamps (up from 10% in 2000), 3.6% received AFDC benefits, and 2.8% of the population was served by the WIC program (down from 8.8% in 2000).

Median Household Income: There has been a slow but steady increase in median household income in Kentucky. In 2001, the median household income was $35,977, rising to $ 37,046 in 2004 and $37,369 in 2005. This compares with $ 50,007 for the U.S. (American Fact Finder 2005-2007 estimates). ***/2010/ The median household income in Kentucky for 2007 has increased to $ 40,299. //2010//***

Persons in Poverty: Based on 2004 statistics, 16.1% of Kentucky's population was below the

poverty level, a slight increase from 15.8% in 1999. Kentucky counties ranged from 34.8% in Owsley County to 6.1% in Oldham County. ***/2010/ In 2007, the proportion of Kentuckians in poverty increased to 17.2%. The county with the highest poverty percent remains Owsley (44.4%) and that with the lowest percent is Oldham (6.2%). //2010//***

An estimated 22% of Kentucky's total population under the age of 18 lived in poverty in 2004, an increase from 20.2% in 1999 (Kentucky County Health Profiles 2004). ***/2010/ In 2007, those under 18 living in poverty increased again to 23.6%. The highest percent of children in poverty continues to be Owsley (55.0%) and the lowest is Oldham (6.0%), both experiencing an increase from the previous year. //2010//***

Unemployment Rate: The unemployment rate in December of 2004 was 5.6%, an increase over the previous year. This ranged from a high in Magoffin County of 12.9% to a low in Woodford County of 3.8%.

/2010/ The unemployment rate for Kentucky in 2008 was 6.4, with Jackson County (located in Eastern Kentucky) having the highest unemployment rate at 11.4 and Fayette and Woodford, both located in Central Ketucky, have the lowest rate at 4.8. //2010//

Educational Status: The educational status of both men and women is closely related to socioeconomic status and has implications for health, as women are key to the provision of health care in most families. Data from 2005 shows that 20.3% of Kentucky mothers had less than 12 years of education. ***/2010/ Data from 2007 shows that 21.2% of Kentucky mothers had less than 12 years of education, an increase from previous years. Todd County has the highest percent of mothers with less than 12 years of education at 46.4% and Hancock County has the lowest percent at 9.2%. //2010//***

Access to Primary Care

Kentucky's predominately rural nature, with almost 50% of Kentucky's population living in rural areas and 98 of its 120 counties categorized as non-metropolitan, means that successful health care recruitment to this population is particularly important for the health of the state. Access issues remain a problem for many families due to poverty, transportation issues and cultural isolation. Of the 120 counties in Kentucky, most of the Health Professional Shortage Areas (HPSA's) are based on the county as the service area. The Kentucky Department for Public Health allocates that majority of the Title V funds to local county health departments for the provision of primary care regardless of an individual's ability to pay.

/2009/ As of July 2008, there are 143 Primary Care HPSA's, 56 Dental HPSA's and 202 Mental Health HPSA's distributed across the 120 counties in Kentucky. There are 167 Medically Underserved Areas/Populations in Kentucky as well. These shortage area designations will provide the counties with an opportunity for better recruitment and retention of providers through programs such as the National Health Service Corps and J1 Visa Waiver Programs. This also enables the county to participate in Rural Health Clinic Programs and Federally Qualified Health Center Programs that serve the low income and uninsured. //2009//

/2010/ As of May 2009, there are 136 Primary Care HPSA's, 57 Dental HPSA's and 78 Mental Health HPSA's throughout Kentucky. According to HealthyAmericans.org, Kentucky is ranked 14th in the nation for the highest number of Primary Care HPSA's and 11th for Mental Health designations. //2010//

The Kentucky Primary Care Association was founded in 1975 as a private, non-profit corporation of community health centers, rural health clinics, primary care centers and other organizations and individuals concerned about access to health care services for the state's underserved rural and urban populations. There are currently 20 Section 330 Health Centers operating in Kentucky that receive funding to help offset the cost for providing care to low income uninsured patients

(http://www.kypca.net/).

Kentucky has 20 primary care sites receiving federal funding and operate through licensed primary care centers and rural health clinics with approximately 58 service locations including a mobile van in 35 underserved counties of the state. The importance of primary care is more widely recognized and centers cover all of the life stages - prenatal, pediatric, adolescent, adult and geriatric. In addition to offering primary care services, other services offered include: Dental, Mental Health/Substance Abuse, OB/GYN, Pharmacy, Other Professional Services and Specialty Care. The affordable, accessible, comprehensive and continuous nature of primary care makes it a vital element to the health care services provided in Kentucky. Formal linkages and collaborative efforts between primary care centers and local health departments vary throughout the state. In 2005, 224,183 individuals received services in the Primary Health Centers. Three Primary Health Centers focus their services toward the homeless and seasonal/migrant farm workers.

The UK Center for Excellence in Rural Health in Hazard, Kentucky is one of the FQHC's and was established in 1990 to address health disparities in rural Kentucky, including a chronic shortage of health professionals and residents' poor health status. This is accomplished through health professions education, health policy research, health care service and community engagement. Nearly 80 percent of the center's graduates are practicing mostly in rural areas of Kentucky. The center houses the North Fork Valley Community Health Center, the host clinic for the East Kentucky Family Medicine Residency Program. The center also houses the Kentucky Homeplace program and Kentucky State Office of Rural Health, which are nationally recognized for improving rural residents' access to health care.

The Pikeville College School of Osteopathic Medicine opened in 1997, becoming Kentucky's third medical school. The mission of the school is to provide family and primary care physicians for Kentucky and Central Appalachia, where there is a severe shortage of primary care practitioners. More than 93% of graduates enter primary care residencies, and 79% of graduates are serving in underserved areas. About half the students are from Kentucky, and another 35-40% are from other Appalachian states, which makes them more likely to serve in rural areas. The PSCOM collaborates with the Kentucky Oral Health Program to provide oral health education to faculty, students, interns, and residents there. The ultimate objective is to improve the oral health status of Kentuckians, especially pregnant women and children.

The Foundation for a Health Kentucky is a non-profit, philanthropic organization working to address the unmet health care needs of Kentuckians. Their approach centers on developing and influencing health policy to promote lasting change in systems by which health care is provided and good health sustained, to: Improve Access to Care, Reduce Health Risks and Disparities and Promote Health Equity.

/2009/ The University of Kentucky College of Medicine will begin training in Fall 2008 to as many as 10 medical students to work in rural communities. The Rural Physicians Leadership track will spend 2 years at the medical college in Lexington and 2 years at Morehead State University in Eastern Kentucky. In addition to the medical school curriculum, students will learn other business skills needed to establish a medical practice in a rural setting. In addition, the UK College of Medicine is partnering with the UK Dental School to develop a network of rural centers for a translational research network, which should also enhance the capacity and access to dental care and other services in areas where there is little available. //2009//

Department for Public Health - Mission

As mandated under KRS 211.005 the definition of core public health was specified at the beginning of the chapter on public health laws. This statute mandates that the Department for Public Health develop and operate all programs for assessing the health status of the population, for the promotion of health and for the prevention of disease, injury, disability, and premature

death. Services provided by the Department for Public Health and all local health departments include: enforcement of public health regulations, surveillance of public health, communicable disease control, public health education, implementation of public health policy, efforts directed to population risk reduction, and disaster preparedness. This identification by statute fosters the development of the role of the Title V agency to provide a comprehensive approach to health. The Department for Public Health, in conjunction with the Title V program, provides preventive clinical services in circumstances where providers are not available.

E-Health

The Department for Public Health is working on a number of infrastructure activities. One is to establish Kentucky as a leader in E-Health. This is also a primary issue of Lt Gov Mongiardo. The E-health Board was created by the previous Governor but will continue with this administration. The Department for Public Health Commissioner, Dr. William Hacker, chairs this important board, as well as e-health committees for ASTHO. The Department for Public Health has taken the first step towards an electronic public health record with a web-based system for hospitals to enter birth certificate and newborn screening data. This system is called KY-CHILD. This system was rolled out to all birthing hospitals in Kentucky in December 2006, and it provides one-time entry of basic demographic data for all children born in the Commonwealth including: vital statistics data (live birth certificate), newborn metabolic screening data and hearing screening data. Immunization data will be the next module to be implemented. This system enhances the follow-up capabilities of the newborn metabolic screening programs. In addition, it has facilitated the development of quality assurance reports for all birthing hospitals. Prior to KY-CHILD, all of this reporting was completed manually with data entry. This web-based system minimizes the possibility of errors within the data, minimizes the discrepancies between data formats and significantly improves the timeliness of data availability. The Cabinet for Health and Family Services recently received an American Council for Technology (ACT) Intergovernmental Solutions Award for the KY-CHILD system.

/2009/ Another infrastructure initiative is moving Kentucky Department for Public Health towards Accreditation, both at the local and state level. A number of committees are actively working with national technical assistance to develop a system for Kentucky and prepare Kentucky's local and district health departments for accreditation. //2009//

Kentucky's Public Health Challenges in Maternal and Child Health

Challenge: Prematurity and Low Birth Weight
Prematurity and low birth weight continue to be a challenge for Kentucky's mothers and infants. Data from Kentucky Vital Statistics, Live Birth Certificate Files show that in 2003, 8.5% of Kentucky's infants are born weighing less than 2,500 grams and 1.7% were born weighing less then 1,500 grams (very low birth weight). In 2005, preliminary data from Kentucky Vital Statistics shows that 8.8% of Kentucky's infants are born weighing less than 2,500 grams and 1.5% were born weighing less than 1,500 grams.

Preterm births (defined as live births at less than 37 weeks gestation) have risen from 12.5% in 1998 to 14.4% in 2003. ***/2010/ Provisional data for 2007 and 2008 estimates that the proportion of preterm births in Kentucky is leveling off and may have peaked, but is still at approximately 15% of all live births for each of the two years. //2010//*** The percentage of preterm births by race also varies significantly. From 2001- 2003, 19.1% of black infants were born prematurely as compared to 13.1% of white. This data was further analyzed to determine the cause of the rising rates in Kentucky - see State Performance Measure Number 8 for additional discussion.

Kentucky has several groups collaboratively addressing prematurity through professional education and dissemination of new information about preterm birth. Through a long-established relationship with the Greater Kentucky Chapter of the March of Dimes Birth Defects Foundation,

public and private health professionals are learning more about the causes and health outcomes of low birth weight and prematurity. The March of Dimes state chapter also hosts an annual Prematurity Summit each Fall that is well attended by Kentucky health providers, professionals and advocates.

/2010/ In November of 2008, more than 180 Kentucky professionals attended the MOD Prematurity Summit. Educational objectives included 1) to improve management of three key issues for the late preterm infant: nutrition, hyperbilirubinemia and hypoglycemia, 2) To identify possible causes and effects of racial disparities in birth outcomes in order to provide better treatment of minority populations, 3) to identify the positive and negative aspects of elective cesarean deliveries in order to provide better counsel and care to patients, 4) to obtain some "best practice" recommendations from the 2008 Surgeon General's Conference on Prematurity, and 5) To receive updates on the Healthy Babies are Worth the Wait initiative. Speakers included James Collins Jr, MD, MPH (Feinberg School of Medicine, Northwestern University, Chicago); Karla Damus, RN, MSPH, PHD (Albert Einstein College of Medicine, Bronx, NY), Diane Ashton, MD, MPH, FACOG, (Deputy Medical Director, March of Dimes, White Plains, NY) and Iffath Abbasi Hoskins, MD, (Lutheran Median Center, Brooklyn NY). Regional faculty included David H. Adamkin, MD (University of Louisville School of Medicine) and Ruth Ann Shepherd, MD, FAAP, CPHQ (Director, Division of Maternal & Child Health, Kentucky Department for Public Health). This conference was presented with sponsorship by March of Dimes and Kosair Children's Hospital.
In addition to the MOD partnership, other state groups are assisting with addressing preterm birth, particularly late preterm birth. The Kentucky Perinatal Association has released a second web-based free CME program covering the morbities of Late preterm infants. The Materal and Infant Health Committe of the Kentucky Medical Association has recently reactivated and has chosen late preterm births as one of its focus areas. In addition, both of these groups are supportive of developing a Kentucky Perinatal Quality Collaborative similar to those in surrounding states. //2010//

The Kentucky Perinatal Association (KPA) has highlighted Prematurity as the main theme of their annual education conference in recent years in cooperation with the March of Dimes campaign. This conference is attended by physicians, nurses, social workers, dieticians, and others working in the field of perinatology.

The KPA has also developed an innovative web-based professional education program called the Health Professional Education on Prematurity (HPEP) course. The course offers free CMEs/CEUs for participants and covers the major physiologic pathways to preterm birth. As of June 5, 2006, more than 520 professionals had taken this on line course, including some from as far away as California. HPEP I, the first module, was entitled "Prevention of Preterm Birth".
/2010/ In October of 2008, HPEP II on "The Late Preterm Birth" became available to health providers in Kentucky. //2010//

These efforts have given the KPA national recognition and honors. In 2006, the Kentucky Perinatal Association received the State Perinatal Association Initiative Award from the National Perinatal Association for the outstanding innovation for the HPEP program. ***/2010/ This award was received again in late 2008 at the National Perinatal Association meeting in San Bernardino, CA.***

In 2009, the KPA annual conference was held at the Lake Cumberland Resort Park in Jamestown, Kentucky. Featured speakers and topic included "Impact of Immigration on Preterm Births" by Russ Kirby, Ph.D., "Progesterone and Preterm Birth: What is the Evidence?" by John O'Brien, M.D., "What's New in Newborn Resuscitation" by Eric Reynolds, M.D., and "Expanded Metabolic Screening in Kentucky: Has It Made A Difference?" by Hubert Ballard, M.D. The featured speaker for the Patricia Nicol Lectureship and Luncheon was Russ Kirby, presenting "Hidden Causes of Perinatal

Mortality". For more information about other presentations and the KPA, please visit their website at http://www.kentuckyperinatal.com/. //2010//

Challenges: Smoking in Pregnancy
According to the CDC, smoking during pregnancy is the single most preventable cause of mortality and morbidity in mothers and babies in the US. Kentucky has nearly the highest rate of smoking in pregnancy of any state. Birth certificate data reported that the number of women who smoked during pregnancy remained fairly constant (27% in 1991 to 23.4% in 2003). Kentucky changed to the new birth certificate beginning in 2004, which reports smoking in pregnancy differently. However, those reports are consistent, indicated we still have 26.7% of pregnant women smoking in the last trimester, and likely throughout pregnancy. The MCH team is currently developing and implementing several projects to address this important health need-- see also National Performance Measure 15. ***/2010/ Our largest initiative is Giving Infants and Families Tobacco-free Starts [GIFTS], which is a case-management approach assisting pregnant women to quit smoking in 9 Eastern KY counties. After 15 months, there have been over 1000 pregnant smokers enrolled; about 20% have successfully quit during the pregnancy. More details can be found on the GIFTS web site: www.mc.uky.edu/KYgifts. In addition, we are now working with both KY ACOG and KY APP chapters on pilot projects to integrate evidence-based practices to promote cessation into daily parctice.//2010//***

Challenges: Health Disparities
In 2007, the rate of the infant mortality for African-Americans in Kentucky is twice that of the Non-Hispanic white population (provisional data). In 2005, the black Infant Mortality rate rose to 15.0/1,000 live births, although overall Kentucky's Infant Mortality remained at 6.8/1,000. Prematurity and Low Birth Weight are also much higher in the African-American population: Preterm birth in blacks is 19%, whites 13.5% (2004), a concern even though Kentucky's population is only 8% African American.

The Department for Public Health is developing the infrastructure for a statewide FIMR program. The program will follow National FIMR guidelines and will work closely with the Louisville Metro Health Department FIMR project and Healthy Start program. The Louisville Metro area contains the largest center of African-American population in the state. Other sites will be selected according to a PPOR analysis.

/2009/ The Bluegrass Farmworker Health Clinic (BFHC) provides services to the ever growing Hispanic population of seasonal migrant workers. BFHC opened a second clinic in Lexington, Kentucky on March 1, 2008.
The Center consists of two facilities to serve migrant and seasonal farm workers in Madison, Fayette, Garrard, Jessamine, Woodford, Bourbon, Clark and Scott counties. According to Dr. Susan Fister, program director and an associate professor of nursing at Eastern KY University, about 70 percent of the migrant farm laborers speak no English, and only about 15 percent speak it well. All staff memebers are bilingual. Because the Center's prospective clients are not covered by Medicaid/Medicare, the maximum charge for those seen by a nurse practitioner is a $10 co-payment, waived for those clients unable to pay. Those in need of dental, laboratory, pharmacy or radiology services are referred to the Center's contracted providers. Besides routine primary medical care, the Center also provides preventative care, such as family planning, TB screenings and blood pressure checks, and health education. //2009//

The Louisville Metro Health Department (LMHD) Healthy Start (HS) Program is a federally funded initiative mandated to reduce the rate of infant mortality and improve perinatal outcomes through grants to
areas with high annual rates of infant mortality; The Healthy Start program has been able to demonstrate improved birth outcomes in this disparate population. For example, Healthy start participants showed Decrease in the frequency of low birth weight births to African American mothers from 15.37% in 1996-1998 to 7.1% in 2003. The program also shows lowered infant mortality, although the numbers are small. Healthy Start continues to target African American

pregnant clients; by 2004, 89% of the clients were African-American. ***/2010/ The Louisville Healthy Start site successfully renewed their grant in June to continue thier work.//2010//***

/2010/ Office of Minority Health/Health Equity
The Kentucky Office of Health Equity (OHE) was established in September 2008; prior to this, Kentucky was the only state in Region IV without an Office of Minority Health. Establishing this office in the Kentucky Department for Public Health (KDPH) was a priority for the current Commissioner, Dr. Bill Hacker. The OHE receives funding from the U.S. Department of Health and Human Services (US DHHS), Office of Minority Health (OMH).
Goals of this office are to identify and establish collaborations to enhance health equity across the state of Kentucky, analyze data specific to health inequities across the state, develop strategies to address health inequities and improve health, and implement a project to eliminate infant mortality inequities.

The infant mortality rate in Kentucky is 7.9/ 1000 live births. However, African-American infants experience mortality at a rate of 15.1/1000, while white infant rate is 7.6/1000. To address this disparity the Jefferson County Infant Mortality Project was developed in collaboration with the Center for Health Equity, based out of the Louisville Metro Department of Public Health and Wellness with the purpose to determine the socio-ecological influences/social determinants that lead to adverse pregnancy outcomes and infant mortality among African-American women in urban communities of Jefferson County. Focus groups were conducted in May and June of 2009, and the results are being analyzed.

Accomplishments of KY OHE include participation in meetings and conferences to strengthen prevention in relation to minority health. Relationships with governmental and non-governmental organizations include the Centers for Disease Control, the Foundation for a Healthy Kentucky, the Center for Health Equity, the Kentucky Department for Public Health, the Lexington-Fayette County Health Equity Interest Group, Saint Joseph Health Care & Hospital System, KET (Kentucky Public Television System), University of Kentucky Hospital, University of Kentucky Office of Multicultural Affairs, Kentucky Office of Quality Improvement & Prevention, Kentucky Governor's Office of Minority Empowerment, and the Kentucky Health Department Director's Association. Other memberships and collaborations include a position on the HIV Prevention Advisory Board, Kentucky Office of Infectious Disease and membership in the KDPH Leadership Executive Council to create a Public Health Manager Model. The Director of KY OHE, in collaboration with the Division of Quality Improvement and Prevention of the KDPH, began an "Unnatural Causes" continuing education training series to inform and educate county health departments across the state of KY. The series began February 2009 and will end in October 2009. //2010//

Challenges: Oral Health
Kentucky has the dubious distinction of being the #1 state for toothlessness. Among our children, nearly half have untreated early childhood caries. Kentucky has a great need for dentists, particularly dentists who will see Medicaid children and pregnant women. A number of initiatives are addressing these issues.

Surveillance: A survey conducted in 2000-2001 resulted in data on the oral health status of Kentucky's schoolchildren. Kentucky's 2001 Children Oral Health Survey showed that nearly one-third of sample of 2-4 year olds were affected by early childhood caries (ECC). 30% had severe ECC, 39% had never been to a dentist and 35% of their parents had not seen a dentist in the last year. Of these, 39% had Medicaid, 15% had KCHIP and 29% had private dental insurance. When 3rd and 6th graders were surveyed, 57% had caries with 29% having visible decay, 51% reported bleeding gums and 15% had signs of gingival inflammation. 20% reported having a toothache in the past month and had not seen a dentist in the last year. Only 29% of these children had

sealants on any molar. /2009/ Attempts to repeat this surveillance study have been unsuccessful to date, due to cost and shortages of dental providers to conduct the survey/exam. //2009//

Fluoride Varnish Program:
Kentucky has 99% of public water systems fluoridated. However, that has not been enough to protect our children. The fluoride varnish program for preschoolers and a sealant program for school-age children both began in July 2003. By 2007, over 1400 nurses at local health departments, the Commission for Children with Special Health Care Needs and various others have been trained to do dental screenings and fluoride applications. Approximately 2000 children per month are receiving treatments through the Healthy Teeth for Tots program.

Dental Sealant Program:
The dental sealant program for school-aged children also began in July 2003. Local health departments screen children and develop agreements with local dentists to provide dental sealants. ***/2010/ In 2008, the Kentucky Oral Health Program has been working with the state information contractor to develop, test and implement a standardized reporting system for sealant reporting throughout Kentucky's health departments. One of the goals of the current HRSA grant: Targeted Oral Health Services Support (TOHSS). //2010//***

State Dental Plan:
The Strategic Planning Process has been a collaborative effort between the Kentucky Department of Public Health and the University of Kentucky School of Public Health Dentistry. The process began with a selection of over 200 key players throughout the state to be a part of the planning process. This listing was eventually culled down to approximately 125 participants who participated in a six-question electronic survey (a SWAT Analysis) which asked for input on the strengths and weaknesses of the provision of oral health services in Kentucky; identification of additional factors that would have a positive (and negative) impact on the achievement of oral health and a vision (ideal state) for oral health. These questions generated responses which have provided the Oral Health Strategic Planning Executive Committee with a baseline from which to develop draft vision, mission, plus-delta and value statements.

/2010/ Regional Dental Centers:
Through the development of the Kentucky Oral Health Network by the University of Kentucky's College of Dentistry, regional dental treatment centers have been established throughout the state. Regional partnerships that were already in place have developed into service provisions in regional centers of care including Hazard and Morehead in eastern Kentucky as well as the expansion of outreach services and the establishment of a dental office for regional access in the western Kentucky town of Madisonville. These sites serve the oral health needs of their region, as well as contribute to assessment and surveillance needs of the Commonwealth, and to the oral health research projects of the university. The University of Kentucky rotates dental students through these clinics as part of instruction in rural dentistry. Their development plans include the incorporation of more unserved adults as well as future plans for dental care for patients with special health care needs. Kentucky's Primary Care Centers provide dental services on a limited basis, with a need for community health center-based dental care in western Kentucky. Efforts continue through the Oral Health Program to engage more primary care centers in the provision of comprehensive dental services. //2010//

/2010/ TOHSS Grant:
Kentucky's Targeted Oral Health Services Support grant is multifold in purpose: (1) KOHP is partnering with two rural health departments to employ case managers to move sealant program patients to restorative care in their community; (2) provides for the design, implementation and evaluation of a state-wide sealant reporting system; (3) raise the awareness of oral health in the state and establish effective oral health community coalitions to empower communities to take action regarding oral health with emphasis on children; (3) foster the development of an environment to increase Medicaid dentists in

the state. The grant provides for a full time Grants Administrator.

Title V Community Forums:
Kentucky combined the TOHSS funding with other Maternal and Child Health funding to be a significant part of community forums to assess health status and health delivery to mothers and children in the state. Dental awareness surveys were taken of all participants and Oral Health was a specific table topic for 9 of the 11 events. The results will be used in the furtherance of the TOHSS grant objectives and with the KOHP in general for future plans. //2010//

/2010/ Challenges: Pediatric Obesity (see also NPM #14). KY has taken steps to combat pediatric obesity since 2004. This year, through a grant from the National Governor's Association, Dr. Hacker, with a wide array of partners, hosted a workgroup on policy that resulted in a large multidisciplinary summit and a policy brief on "Shaping Kentucky' Future: Policies to Reduce Childhood Obesity", available at www.fitky.org/ViewDocument.aspx?id=258. The Summit on May 12. 2009, was attended by 280 people including pediatricians, hospital administrators, YMCA staff, lawyers, business people, university representatives, public health professionals, advocacy groups, and families. National Speakers included Michelle Klink, Sr. Advisor for Leadership for Healthy Communities (RWJ); Jayne Greenberg, Miami Dade County Schools, and Susan Cooper, Commissioner, Tennessee Dept of Public Health. Local speakers included Commissioner Hacker, Cabinet Secretary Janie Miller, and Dr. Joshua Honaker, president of KY AAP.//2010//

Kentucky's Public Health Successes in Maternal and Child Health
While many public health challenges face Kentucky's health providers, there have been some exciting success stories over the past decade in Kentucky.

KIDS NOW Early Childhood Initiative (2000).
During the 2000 State Legislative Session, a program called "KIDS NOW!" was introduced. "KIDS NOW!" is a comprehensive plan that addresses issues for children from the prenatal period (folic acid supplementation) to birth (home visitation and newborn hearing screening) through age 5, including childcare. This program added $50 million new dollars to programs centered on children in Kentucky, and $30 million dollars was allocated specifically for programs dealing with maternal and child health. Funded through the national Master Tobacco Settlement, Kentucky's legislature passed a bill that allowed 25% of this funding to be directed to children and families; thereby assuring significant and ongoing support for this population. Outcome Measures for KIDS NOW! include universal newborn hearing screening, oral health, immunization status, low birthweight, births to teens and child safety.

The Vision of this Early Childhood Development Initiative was all young children in Kentucky are healthy and safe, possess the foundation that will enable school and personal success, and live in strong families that are supported and strengthen within their communities. The KIDS NOW programs continue to expand and make a positive impact on children and families. The programs include: Healthy Babies Campaign, Folic Acid supplementation, Substance Abuse Counseling and Treatment for Pregnant Women, Universal Newborn Hearing Screening, Immunizations for Underinsured Children, Eye Exams, Oral Health, HANDS Home Visiting Program, Early Childhood Mental Health Program, Healthy Start in Child Care, and First Steps, Kentucky Early Intervention System. In addition, they support efforts to improve the quality of childcare across the state, including childcare subsidy, training efforts, and the STARS rating scales. Oversight and monitoring is led by the Early Childhood Authority, an appointed body housed in the Department of Education.

/2008/ These programs continue to utilize dollars from the Tobacco Settlement Funds under the oversight of the Early Childhood Authority, located in the Kentucky Department of Education. Dr. Steve Davis, Deputy Commissioner, continues to represent the Department for Public Health on

that board. //2008//

/2008/ Expanded Newborn Metabolic Screening
Kentucky passed legislation to expand the Newborn Screening Program from 4 metabolic and heritable disorders to 29 in March 2005 and the program was in full operation by December 2005, including case management for positive or abnormal screens. In the first few months of expanded screening, 24 cases of metabolic diseases were confirmed based on positive screens. A number of these were fatty acid oxidation disorders such as MCAD for which there was no screening prior to December 2005. Identification of these newborns was not previously possible. Kentucky belongs to the Regional Collaborative Four which is the first of seven regions in the nation to employ tandem mass spectrometry in all its regional member states. KY's lab has exceeded the metrics set for Region IV by Mayo Clinic. Dr. Stephanie Mayfield, Medical Director of the Kentucky State Laboratory, presented a paper on the first three months of performance metrics for expanded screening at the 6th Annual International Society of Newborn Screening to be held in September 2006 in Japan. Kentucky has a case management system that tracks 100% of the newborns screened, cases confirmed, and follow-up case management and treatment In the first year We identified over 178 true positives. The advisory committee, including both experts and parents, continues to meet quarterly. Quality indicators and interesting cases are reviewed. Information regarding the Newborn Screening Program including Parent Brochures and Fact Sheets on each of the tested diseases, Health Care Provider Fact Sheets and Screening Guide and other available resources including the Commission for Children with Special Health Care Needs, the March of Dimes and the National Newborn Screening and Genetic Resource Center may be accessed at http://chfs.ky.gov/dph/ach/ecd/newbornscreening.htm //2008//
/2010/ The Kentucky Newborn Screening program has expanded to 49 disorders. KY is actively participating in HRSA Region IV Genetics Collaborative, and hosted a meeting with partners on April 14, 2009. Discussions included the Midwest Emergency Medical Serivces for Children Information System which provides professional and parents access to emergency care and disaster preparedness plans for newborn screening disorders. Also Education for medical homes, the True Positive Disease Database; Sample Exchange program; and the development of the Inborn Errors of Metabolism Informaion System, which develops protocols and treatment methods. Multistate collaborations are necessary to develop these best practices, since these disorders are so rare.

HANDS Home Visiting Program
The HANDS program was developed by Dr. Steve Davis in the Department for Public Health in 1998 in response to high rates of child abuse. It was modeled after the Hawaii program and the national Healthy Families curriculum. The purpose of this program is to provide home visitation to overburdened first-time families to assist them in meeting the challenges of parenting beginning prenatally and continuing during the child's first two years of life. Goals of the program are positive pregnancy outcomes, optimal environments for child health and development, and family self-sufficiency. These are the building blocks to create the environment for children to live in healthy, nurturing and safe homes and to reduce the likelihood of child abuse and neglect over the long term. HANDS began in eleven pilot counties in December of 1998 and in the spring of 1999, four additional counties were added. In 2001, an additional thirty-two counties were added bringing the total participating counties to forty-seven. 2002 brought about 54 additional new counties totaling 101 participating counties and in 2003, statewide coverage of all 120 Kentucky counties was achieved.

HANDS uses a comprehensive curriculum based on Growing Great Kids. The program uses both professionals and paraprofessionals, with extensive training for all including ongoing training requirements. Paraprofessionals are supervised by professional staff at regular intervals. HANDS is a strengths-based program. Many topics are covered with these high risk families, including pregnancy, interconception, infant & child health education, safety in the home, decision-making and problem solving skills, goal setting, parent-child interaction, early brain development, parenting skills, and support and

community referrals. Establishing caring relationships with the family is key. Families are referred thru a screening tool, then have a comprehensive assessment, and services begin with weekly visits.

Evaluation is by an independent outside evaluator and links HANDS service data with birth certificate data, and compare to a similar population. In evaluations focusing on our teen participants seen during their pregnancy, the participants showed lower rates of prematurity and low birth weight, less very low birth weight, fewer congenital anomalies, lower infant mortality. Outcomes appear to be dose dependent; i.e. those participants who had 16 or more visits had half the premature birth rate of the comparison group. Those who started the program in the first trimester had only 1/3 the rate of preterm birth. In addition, evaluations now have demonstrated improved educational status of the mother, improved employment, lower than expected incidence of developmental delay, less ER utilization, and much less substantiated child abuse and neglect than the expected rate. This program is funded by Tobacco Settlement monies through the KIDS NOW program. Services are limited to first time parents and only until the child is two due to funding limitations. Discussions are underway to expand the program.

/2010/ Perinatal Depression
The Kentucky H.A.N.D.S. Reach Out about Perinatal Depression bridges the gap in Kentucky's identification and treatment of perinatal depression. Collaborative efforts between the Cabinet for Health and Family Services and the Department of Mental Health, Developmental Disabilities, and Addiction Services accomplishes this by utilizing existing program structures and enhancing their ability to provide perinatal depression screening and refer those who require additional assessment/treatment to appropriate providers. The project provided training to professional home visitors to enable them to implement use of the Edinburgh depression screening and provide them with a referral to the local comprehensive care center for assessment/treatment by a mental health specialist. These mental health professionals receive extensive training on parent-infant dyadic therapy and cognitive behavioral techniques. Addressing perinatal depression is an investment in the health and wellness of all Kentuckians and will result in improved health of women during the perinatal period, improved birth outcomes, and improved social emotional health of parent and children. Birth outcomes (low birth weight, prematurity, infant mortality) and social emotional development scores (Ages and Stages: SE) for H.A.N.D.S. participants were evaluated. //2010//

Early Childhood Mental Health

The Early Childhood Mental Health Program is a program funded through KIDS NOW. A budget of $775,000 has been allocated for next fiscal year to support a mental health program for children birth to five enrolled in early care and education settings. The overall goal of the program is to support the social and emotional growth of Kentucky's children birth to age five by emphasizing the importance of nurturing relationships in multiple settings. Eighteen Early Childhood Mental Health Specialists have been employed through the community mental health centers. The services provided by the specialists include assessments, therapeutic services, training and resources for public and private providers. Additionally, the specialists provide and sponsor training and consultation to child care providers and fellow clinicians to assure high quality care and to increase the number of qualified professionals to serve these children. The program is a cooperative effort between DPH, DMH/DD/SA, KDE, and Cabinet for Health and Family Services. ***/2010/ The program will be expanded and enhanced by a new SAMSHA grant, KY Systems to Enhance Early Development (KY SEED). In October 2008, Kentucky was awarded a grant through the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide services to children birth to five with severe emotional disturbance. This grant is being implemented through a collaborative effort between the Department for Mental Health, Developmental Disabilities, and Substance Abuse (DMH/DD/SA) and the Department for Public Health. The project director position***

will be housed in the department for public health so as to facilitate collaborative relationships between early childhood serving agencies. The ultimate goal of this six year grant it to provide a system of care for ALL children birth to five with social and emotional health needs and their families. //2010//

Kentucky Folic Acid Partnership
The KY Folic Acid Partnership (KFAP) began in September 1999 and has expanded to 92 members representing 56 agencies/organizations and businesses. The KFAP encourages community activities to educate about the use of folic acid to prevent birth defects and has expanded their role to educate communities about preterm birth prevention.***/2010/ In FY09 (July 1, 2008 though April 30, 2009), the KFAP has completed 308 prematurity prevention activities and has reached 4,567,021 participants; the KFAP has completed 135 folic acid activities and has reached 225,630 participants.//2010//***

The Title V Program -- Access, Assurance and Policy Development
Traditionally, the Title V program has focused on providing access to maternal and child health services through supporting local health departments and through contracts with universities to deliver services within the community setting and on site for the maternal and child health population. Although this continues to be the focus for the Title V programs, a changing health care environment has opened other opportunities to improve the health of women, infants, children and children with special health care needs. Assurance through partnerships, cooperative agreements and contracts will be discussed throughout the Title V Annual Report and Application.

Local Health Departments continue to be the presence of the Department for Public Health at the local level. As in past years, the majority of Title V funding is allocated directly to local health departments to support their activities benefiting the maternal and child population. Local health departments conduct community needs assessments on a regular basis that guide their programming priorities while the Department for Public Health provides regulatory guidance and standards of care, in addition to training opportunities and other resources.

The vast majority of Title V Block Grant funding is allocated to local health departments to support community programs that work toward attaining MCH performance and outcome measures. (See budget for details of Title V services provided in Local Health Departments) In addition to MCH Title V funding, revenue from several major sources including KIDS NOW Early Childhood Initiative, state general funds, and other federal grants support MCH services in local health departmetns.

The trend in KY is that the direct community services for maternal and child health is occurring more frequently in traditional medical homes than in years past. Factors influencing this trend include more public financing (such as KCHIP) and more effective healthcare systems utilizing a Primary Care Provider. This is occurring more commonly in the areas of family planning, prenatal and well child preventive services. Some rural counties do lack key health providers such as OB/GYNs and Pediatricians. In these cases, local health departments do provide preventive and direct clinical services, as a safety net to assure services are provided regardless of the ability to pay.

The Kentucky Public Health Practice Reference (PHPR), developed by DPH, serves as the guidance for clinically based information to support patient-centered health care provided by local health departments. Additionally, the PHPR provides supportive information to assist the professional in providing services within the community outside the clinic setting. Guidelines included in the PHPR will enhance the public health professional's knowledge and understanding of population-focused practice and reflect current information and recognized treatment recommendations from appropriate literature and authorities. Additional protocols and guidelines that are desired at the local level must be jointly developed by nurses, advanced practice nurses, physician assistants and their collaborating physicians, as indicated. The entire PHPR and semi-

annual updates to the document are available on the DPH website at:
http://chfsnet.ky.gov/health/dph/dafm/

All LHD's clinical and administrative operations are reviewed on a regular basis under the DPH's Quality Assurance Review Process. Areas reviewed include the Breast and Cervical Cancer Program, the Family Planning Program, Child Fatality Review, Pediatric Clinical Services, the Tobacco Program and the Lead Poisoning Prevention Program. Using Kentucky's Public Health Practice Reference as the quality assurance standard, a team of registered nurses visits each local health department to conduct staff interviews and clinical record reviews. Issues for discussion include barriers to access, continuing education needs and data collection quality. Specific to the family planning program, appropriateness of care and adherence to the federal guidelines is ascertained during this review. Following an exit interview with key staff, a written report is prepared by the team and the local health department responds with a quality improvement plan to address identified issues in a timely manner.

/2009/ The MCH Title V Block Grant supports a number of other projects for the MCH effort. These include: Maternal Mortality Review, Fetal and Infant Mortality Review (FIMR), the Mental Health/Mental Retardation Suicide Prevention personnel, the UK College of Public Health, MCH Institute. Additional programs supported will be Regional Neonatal Centers at the universities, Injury Prevention program, Young Parents Program (See National Performance Measure # 8 for a description of this program), the Child Development Evaluation program, Nutrition education, Pediatric Assessment and Prenatal training. //2009//

As noted earlier in this section, universities are also important partners with the Department for Public Health in the continuum of care for Kentucky's maternal and child populations. Kentucky's two tertiary centers are the University of Kentucky (Lexington) and the University of Louisville. They, as well as Eastern and Western Kentucky Universities, Kentucky State University, Pikeville School of Osteopathic Medicine and others collaborate on many levels including training for health care providers, research and the provision of resources for providers throughout the state. Some examples of trainings offered through University contracts includes Prenatal training at the University of Louisville (U of L), Well Child Preventive Health training at U of L and the University of Kentucky (UK) and Breast and Cervical Cancer Screening training at U of L and UK. Family Planning training is provided through the Emory Regional Training Center, Emory University.

Other Key Partners in Maternal and Child Health
In addition to governmental linkages, the Department for Public Health also collaborates with a number of associations, voluntary organizations and advocacy groups with an interest in maternal and child health issues.

The March of Dimes Birth Defects Foundation is another strong partner. ACHI staff participates on the Greater Kentucky Chapter State-Level Program Service Committee and in the allocation of direct community grants supporting maternal and child health programs at the local level. Additionally, staff work to implement relevant programs and projects; such as preconceptual planning, prenatal lead poisoning prevention and prematurity/low birthweight awareness and prevention. These projects and programs are discussed throughout the document.

Kentucky is currently working with March of Dimes and Johnson & Johnson Pediatric Institute on a major initiative to reduce rates of preterm birth in Kentucky. The initiative is called "Healthy Babies are Worth the Wait".

The Kentucky AAP chapter, has partnered with us on a number of initiatives and that relationship is growing stronger. Our collaborations include mental health trainings, child abuse and suicide prevention, oral health, and disaster preparedness. Dr. Shepherd participates on their executive committee and strategic planning. ***/2010/ The chapter is working closely with Public Health on initiatives including childhood obesity, smoking cessation in pediatric practices, and strategic planning. In April the chapter awarded Dr. Shepherd their "Friend of the***

Children" award for outstanding service to mothers and children in the Commonwealth. //2010//

The Kentucky Chapter of ACOG is also partnering with the Department for Public Health on several initiatives, including "Healthy Babies are Worth the Wait", the MOD prematurity steering committee, and a pilot project on smoking in pregnancy. They have included presentations on these topics at official ACOG meetings and invite Dr. Shepherd to attend all their executive committee meetings. ***/2010/ Dr. Connie White, current president of KY ACOG, left her private practice in March to join Public Health as the Division Director for Women's Health. //2010//***

Other key partners include the Kentucky Perinatal Association, Kentucky Hospital Association, Kentucky Early Childhood Authority, Migrant Health Coalition, Foundation for a Healthy Kentucky, Kentucky Child Now, SAFE KIDS, Kentucky State Coalition of Primary Care, Kentucky Center for School Safety and Kentucky Disabilities Coalition, etc.

The Commission's Role in Assuring the Health and Well-Being of CSHCN

/2010/ The Commission for Children with Special Health Care Needs has a long history dating back to 1924 when it was created by the State Legislature in response to a request from the Rotary Club to provide treatment to children with orthopedic conditions through itinerant clinics across the state. The focus on community-based systems of care continues today. In addition to being a direct services provider, the Commission has assumed a leadership role in assuring state and local systems of care for children and youth with special health care needs (CYSHCN) and in promoting a broader definition of health for CYSHCN and their families as defined by the World Health Organization: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The Commission has a long and noteworthy reputation for treating children with specific physical diseases, conditions and disorders in a clinical setting. Many areas of the state depend upon Commission sponsored clinics to access specialty care. The Commission remains committed to surveying areas of need and continuing to provide care for physical disabilities and providing educational opportunities needed by the CYSHCN population, including childhood obesity.

As a national leader in developing systems to support the transition of CYSHCN to adulthood, KY became the first state to develop a Title V performance measure for transition to adulthood in 1997. This initiative has continued to be an area of growth and continues to evolve to meet the needs of our children who beginning at age 2.

Successful administration of Kentucky's early intervention program for 4 years affirmed our ability to identify and resolve service delivery problems associated with the needs of developmentally delayed children. During this period the Commission also discovered that there was available workforce capacity to provide administrative and technical support services for this population. Finally, a careful, detailed analysis of the declining population in need of clinical care for many of the diseases we traditionally treated forced us to consider other segments of the special needs community in need of services that drew on our expertise if we wanted to remain relevant in addressing the needs of CYSHCN.

The pilot project providing medical consultative support for medically fragile foster children and their families provided another platform from which to assess the needs of a growing population of at risk children. The Commission with the support of Cabinet leadership began careful yet intense collaboration with the Department for Community Based Services (DCBS) began defining the scope of service and negotiating with Cabinet leaders to create a MOU to provide the child welfare system with nurse consultants.

Today, foster care nurses continue to remain visible in all counties in their assigned areas, make visits to all child welfare offices, and provide case-specific consultation for children in the program.

The Commission continues to focus on the expanded need to serve children statewide. The agency has seen continued growth in services to the newborn population in the provision of newborn hearing screening. The Kentucky Early Hearing Detection and Intervention (EHDI) program consistently reports the screening of over 97% of Kentucky newborns with referrals for diagnostic screening given to all children reported to have a risk factor for hearing loss. The program is currently focused on obtaining the follow-up diagnostic testing results for the newborns who have been identified as at-risk for hearing loss.

The agency also continues to monitor and realize the growing need to provide culturally sensitive training to staff and resources to families who are limited in English proficiency (LEP). The Commission has an LEP coordinator who regularly works with office staff to educate on Cabinet for Health and Family Services (CHFS) LEP policies and guidelines. In 2007, the LEP coordinator visited every Commission office to provide training to each staff member on current policies and to provide resource materials. As well, all staff are encouraged to visit the CHFS Language Access Section's website, which provides current updates, links to interpretation resources and all Cabinet policies regarding interpreter and translation processes. All Spanish interpreters must be deemed qualified by the Cabinet and all materials translated into Spanish must be submitted through the Language Access Section. Translated materials are provided on the Commission's website. All sign language interpreters must hold a license through the Board of Interpreters. Additional languages are interpreted by qualified interpreters throughout the state. As well, the agency utilizes a telephone interpreter services when needed. The agency has one bilingual employee in the central office and holds a contract with another bilingual individual in the Lexington office.

In 2009, as part of the Family to Family Grant award, the agency will begin recruiting and coordinating family partnerships throughout the state, so families may act as mentors for each other. This will allow families to maximize their knowledge and access to community-based services, as well as their overall understanding of information regarding health care needs and resources for children.

As a result of state revenues shortfalls, the Northern Kentucky office was closed in June 2008. The patients and services of the Hopkinsville office were merged with the office in Bowling Green in January 2009. Letters were mailed to all families who were enrolled in Commission services, well in advance of the closure dates, to make them aware of the change and to allow them to select a different regional office of their choice through which to have their services coordinated. Most families responded to the letters and selected a different office. Medical services that were contracted for those families in their local area were not changed. //2010//

/2010/ For additional information, see the following links:
Shaping Kentucky's Future: Policies to Reduce Obesity: www.fitky.org/ViewDocument.aspx?id=258
Kentucky PRAMS Pilot Report: http://chfs.ky.gov/dph/mch/default.htm
Kentucky Child Fatality Review Annual Report: http://chfs.ky.gov/dph/mch/cfhi/childfatality.htm
GIFTS Smoking in pregnancy project: www.mcuky.edu/KYgifts
Healthy Babies are Worth the Wait: www.prematurityprevention.org (includes community toolkit)
KY Folic Acid Partnership: www.kfap.org (also includes prematurity prevention community toolkit)

Kentucky Suicide Prevention Group: http://kentuckysuicideprevention.org/index.html
Kids NOW Initiative: www.kde.state.ky.us/KDE/ //2010//
An attachment is included in this section.

B. Agency Capacity

Assurance for the Health of Kentucky's Women, Infants and Children

Capacity - Policy

/2010/ Governor Steve Beshear has been actively promoting child health. In the fall of 2008, he delivered on a campaign promise to enroll more children in KCHIP. DPH is assisting with locating potentially eligible families and assisting them in the streamlined enrollment process. The Governor's office estimates that 86,000 KY children are eligible for KCHIP and not enrolled. In addition, the Governor has established two Task Forces. The Task Force on Early Childhood Education and Care is reviewing the state's current early childhood programs and will make recommendations to enhance or expand them, or identify gaps to fill. The Task Force on Philanthropy is to focus the states philanthropic groups on a few worthy causes that could have more impact with a combined effort of support. MCH programs have been presented to both groups and were well received.//2010//

The Kentucky Medicaid program has maintained its committment to Kentucky's women and children despite challenging financial times. Eligibility for services for pregnant women and children remains at a high level and dis-enrolling women and children has not been supported as a cost-cutting strategy. The commitment to KCHIP also remains firm.

The use of Master Tobacco Settlement dollars to invest in children has also remained a solid commitment despite difficult financial times. In the 2000 Kentucky Legislative Session, the "KIDS NOW!" program was created from tobacco settlement money supporting children from the prenatal period (folic acid supplementation) to birth (home visitation and newborn hearing screening) through age 5. This program added $50 million to programs centered on children in Kentucky, and in excess of $30 million was allocated specifically for programs dealing with maternal and child health, and that commitment remains. Use of the funds and outcomes of the programs are reviewed quarterly by the Early Childhood Authority, and at least annually by the Tobacco Oversight committee.

Capacity - Kentucky Statutes
State statutes relevant to Title V programs are listed below and may be viewed in their entirety at http://lrc.ky.gov

Maternal Health

KRS 194A.095 Directs that an Office of Women's Health be established within the Cabinet for Health and Family Services.

KRS 214.160 Requires syphilis testing for pregnant women.

Perinatal Health

KRS 211.651 -- KRS 211.670 Authorizes the Birth Surveillance Registry administered by the Division of Adult and Child Health Improvement. Allows Birth Surveillance Registry personnel to review and receive records from medical laboratories and general acute-care hospital if voluntarily participating in keeping a listing of both inpatients and outpatients.

KRS 214.155 Authorizes newborn screening for inborn errors of metabolism and other hereditary disorders.

This regulation is currently being revised to reflect the expanded newborn screening legislation that was passed in the 2005 Kentucky General Assembly.

KRS 304.17A-139 to provide for a $ 25,000 cap on coverage for inherited metabolic diseases on medical formulas and a separate cap of $ 4,000 on low-protein modified foods for each plan year.

KRS 311.6526 to requires guidelines for responding to abandoned infants, including preserving the confidentiality of the parent, and define "newborn infant" as an infant less than seventy-two (72) hours old. Providing implied consent for treatment and confidentiality for the person releasing the infant with the provision unless indicators of child abuse or neglect are present.

HB 108 AN ACT relating to the protection of unborn children.
Create a new section of KRS Chapter 507 to include unborn child after viability within the definition of "person" for the purposes of the criminal homicide statues to criminalize fetal homicide; create a new section of KRS Chapter 532 to provide a sentence enhancement for criminally causing a miscarriage or still birth of a fetus before viability.

Pediatric

KRS 156.501 established a full-time position of education school nurse consultant within the Department of Education and specify employment requirements and job duties to include development of protocols for health procedures, quality improvement measures for schools and local health departments and data collection and reporting.

KRS 200.650 -- KRS 200.676 Kentucky Early Intervention System/ First Steps.

KRS 211.680 -- Authorizes the Department for Public Health to coordinate efforts to reduce the number of child fatalities through reviews of unexpected child deaths.

KRS 211.900 -- KRS 211.905 Authorizes comprehensive lead poisoning prevention services.

KRS 213.410 -- Authorizes SIDS services.

KRS 214.034 -- KRS 214.036 Establishes immunization requirements for children.

KRS 214.185 Permits diagnosis and treatment of minors for contraception, sexually transmitted diseases and pregnancy related care without parental consent.

KRS Chapter 95A.200 to establish a Safety Education Fund to be administered by the Commission on Fire Protection Personnel Standards and Education to initiate education programs in the public schools and other agencies to reduce and prevent injuries and the loss of life.

Children with Special Health Care Needs

KRS 194A.030(7) Creates the Commission for Children with Special Health Care Needs

KRS 200.460 -- KRS 200.499 Commission for Children with Special Health Care Needs. Establishes the organization and guidelines for providing services to children with special health care needs.
KRS 200.550 -- KRS 200.560 Provides for the detection and treatment of children and adults with bleeding disorders.

KRS 211.645, 211.647 and 216.2970 Universal Newborn Hearing Screening.

KRS 213.046 When a birth certificate is filed for any birth that occurred outside an institution, the

Cabinet for Health and Family Services shall forward information regarding the need for an auditory screening for an infant and a list of options available for obtaining an auditory screening for an infant.

911 KAR 1:070. (Formerly 902 KAR 4:070) Implements the services of the Commission for Children with Special Health Care Needs.

MCH General

KRS 211.180 Gives the Department for Public Health the responsibility for public health, including improving the health of mothers, infants and children.

HB 67 To allow ARNPs and RNS to distribute nonscheduled legend drugs from a Department for Public Health approved list in local health departments.

2005 Legislation

SB 2 AN ACT relating to health information. Creates the Kentucky e-Health Network Board to oversee the development, implementation, and operation of a statewide electronic health network.

SB 24 AN ACT related to expanded newborn screening.

SB 56/HB 170 related to drugs. Requires the restriction of the sale and display of drugs containing ephedrine or pseudoephedrine; requires identification and limits the quantity available for purchase.
This legislation was a part of Governor Fletcher initiative as a way to stop or reduce the production, usage and sale of Methamphetamine in Kentucky.

SB 172 An ACT relating to health and nutrition in schools. Requires 30 minutes of physical activity each day in schools or 150 minutes per week; to prohibit, beginning with the 2006-2007 school year, a school from preparing or serving deep-fried foods in the cafeteria during the school day, require each school to publish a school menu that specifies nutritional information: require each school to limit access to no more than one day each week to retail fast foods in the cafeteria. Also created the Get Healthy KY! Board.

HB 267 State Budget Bill includes funding for Smoking Cessation Counseling for Pregnant Women covered by Medicaid.

HB 272 AN ACT relating to revenue and taxation. Changes many provisions of state income tax, corporate tax and cigarette excise tax. For low income families the tax threshold raised to the federal poverty level. Cigarette excise tax rose from 3 to 30 cents. 1 cent of the increased cigarette excise tax is dedicated to cancer research.

HB 304 AN ACT relating to international adoption. Requires Kentucky courts to recognize a final adoption decree from a foreign country.

HB 323 AN ACT relating to the establishment of the Off-Road Motorcycle and ATV Commission. One member of the Commission is to be the Executive Director of the Brain Injury Association of Kentucky.

HB 353 To allow public and private school students to self-administer asthma medications when the school receives written authorization from the parent and health care provider.

/2007/ 2006 Legislation

HB 3 Adds offenses including child pornography to the definition of sex crimes and strengthens restrictions to keep sex offenders away from children.

HB 45 Kin Care Support Program. Requires the Cabinet to staff an 800 # for grandparents with referral information for programs that might assist them in raising Grandchildren. Establishes an affidavit for the provision of educational and health services for individuals who were not the legal guardian for the child in question. Establishes the Cabinet as lead agency in developing the affidavit, provides for penalties if statements on the affidavits are knowingly untrue, and exempts service providers when they act in good faith under the authority of the affidavit.

HB 57 Cabinet for Health and Family Services to maintain a statewide registry for organ and tissue donation.

HB 68 Permits the donation of wholesome food by retail food establishments; requires the CHFS to amend regulation to provide an action process to guide potential donor organizations.

HB 90 Graduated Driver's Licenses for Teenagers.

HB 94 Exempts manufactured home parks, mobile home parks, or recreational vehicle parks operated on a temporary or seasonal basis by local governments from Department for Public Health sanitation regulations.

HB 111 Allows for social security numbers of persons applying for marriage licenses to be supplied automatically to Department for Community Based Services and stored for possible future use by Child Support personnel.

HB 117 Includes heritable disorder testing as recommended by the American College of Medical Genetics; adds the lead based paint provisions of SB188; adds members to KEIS-ICC; adds ATV helmet provisions for children 16 or over; adds primary seat belt provisions effective 1/1/07.

HB 181 Requires health benefit plans that provide benefits for prescription drugs to include an exceptions policy or an override policy which provides coverage for the refill of a covered drug dispensed prior to the expiration of the insured's supply of the drug; and mandates that insurers provide notice in existing written or electronic communications to pharmacies doing business with the insurer, the pharmacy benefit manager if applicable, and to the insured regarding the exceptions policy or override policy.

HB 283 Increases appropriation for Low Income Home Energy Assistance Program (LIHEAP) by $10 million.

HB 374 Requires a government agency when filing an administrative regulation, to conduct an analysis to explain how a regulation will affect regulated entities; requires that electronic registration be available from a centralized state government Web site developed and maintained by the Commonwealth Office of Technology; mandates a small business ombudsman at each cabinet to respond to small business inquiries concerning administrative regulations and the process for submitting comments; and require a fiscal note relating to any aspect of state or local government with projected cost or cost savings to the state and all its affected agencies as well as local governments.

HB 380 Budget included additional funding for Childhood Lead Poisoning Prevention, the Poison Control Center, continuation of the KCHIP program, Teacher salaries, and Education Technology.

HB 475 The Department of Education, in cooperation with the Department for Public Health, shall develop and make available information about meningococcal meningitis and its vaccine to local school districts in an efficient manner including posting the information on its Web site.

HB 540 Requires that the Department for Public Health develop a hepatitis C awareness and information program and report to the Interim Joint Committee on Health and Welfare by December 6, 2006 and every six months thereafter.

HB 646 Creates the Governor's Wellness and Physical Activity Program, Inc.

SB 19 Directs electronic health information and Kentucky E-Health to include living will, organ donation and advance directive information.

SB 58 Adds CHFS CIO (or his designee) to the Telehealth Board.

SB 61 Ratifies Office of Health Policy reorganization.

SB 65 Controlled substances prescriptive authority for ARNPs.

SB 98 Requires administrative bodies to consider the costs to state or local governments when promulgating administrative regulations.

SB 106 An Act relating to Breastfeeding.

SB 146 Makes several adjustments to the current Supported Living Program.

SB 174 Creates a centralized resource and referral center within the Department for Mental Health and Mental Retardation Services if federal, state, or other funds are available; designs the center as a one-stop, seamless system to provide aging caregivers with information and assistance with choices and planning for long-term supports for individuals with mental retardation and developmental disabilities.

SB 180 Provides statutory authority for CHFS to: 1) Operate the Kentucky Physicians Care Program; 2) Provide a toll-free hotline referral service to assist citizens who do not have health insurance to access volunteer and free healthcare services and resources; 3) Establish enrollment sites at the DCBS for individuals referred; and 4) Create a mechanism for assisting uninsured individuals to receive no-cost healthcare services through the program.

SB 202 Requires the Department for Public Health to establish a multigenerational osteoporosis prevention and education program to promote public awareness of the causes of osteoporosis, options for prevention, the value of early detection, and treatment, and to increase health care provider awareness of national clinical guidelines related to the prevention, diagnosis, and treatment of osteoporosis.

SJR 176 Joint Resolution to submit an application in response to any solicitation from the federal CMS for states to participate in a Medicaid pay-for-performance demonstration to improve the quality of long-term care if CMS provides funding for the administrative and operational costs; explore opportunities to participate in federal pay-for-performance demonstrations that would provide financial incentives to nursing facilities for improvement in the outcomes of care.

HR 324 Encourages the Environmental and Public Protection Cabinet (EPPC) to work with the Cabinet for Health and Family Services to establish a toxic mold program for residential buildings and schools.

SJR 184 Encourages the Cabinet to establish the Kentucky Youth Development Coordinating Council; establish membership and permit the creation of subcommittees of the council; require the University of Kentucky Cooperative Extension Service to perform the administrative functions of the council; identify the duties of the council; mandate that the council submit a report to the Governor and the General Assembly by September 1 of each year; and require all appropriate

executive, judicial, and legislative branch agencies to cooperate with the council.

SR 323 Department for Community Based Services modernization. //2007//

/2008/ 2007 Legislation

Boni Bill - (Named after the Social Worker murdered in 2006.) HB 362 creates a safe work environment for employees and security for workers in the field, and adds 67 new positions to help lesson the work load of overworked Social Workers.

Breastfeeding- SB 111 excuses breastfeeding mothers from jury duty.

Human Trafficking-SB 43 makes transportation of persons for forced labor, sexual exploitation or other illicit activities a felony.

Sex Offenders-SB 65 requires convicted sex offenders to disclose their Internet user names or other online identities.

Fire-Safe Cigarettes-HB 278 requires fire safe paper that extinguishes itself if there is no puffing.

Once again the Booster Seat Bill was introduced but failed to pass in the Kentucky Legislature. //2008//

/2009/ 2008 Legislation

HB 91 Bullying Bill: Requires school districts to have plans, policies, and procedures dealing with disruptive and disorderly behavior including harassment, intimidation or bullying.

HB 186 Student Dental Health Certificates: Requires a dental exam the first year that a 3, 4, 5 or 6 year-old child is enrolled in a public school, public preschool or Head Start program beginning with the 2011-2012 school year.

HB 187 Tuberculosis Risk Assessment: Requires applicants for certification as a family child-care provider to produce a copy of the results of a Tb Risk Assessment.

HB 371 Trauma Care: Provides authorization for the creation of a state Trauma Care system. No funding was provided.

SB 120: Booster Seat: Requires a child under age 7 years between 40 and 50 inches in height be secured in a child booster seat.

The Budget Bill included $250,000 for School Based Health Centers. //2009//

/2010/ HB 5 Defines "permanent childhood hearing loss"; requires the Commission for Special Health Care Needs to establish standards for infant audiological assessment based on national standards; and requires the Commission to report results for assessments that contains evidence of hearing loss to the parents and physician

HB 99 Permits out-of-state physicians to practice medicine in Kentucky as a charitable healthcare provider by demonstrating they have a license in good standing in the state where they reside; and permits optometrists to practice as charitable providers outside their office setting

HB 144 Increased the state excise tax on cigarettes by 30 cents (total tax now 60 cents/pack). Went into effect April 1, 2009. Federal excise tax was also increased by 61 cents during the same time period.

HB 383 Requires the Department of Education to establish a formal workgroup to study high school sports safety; report results of study to the interim joint Education Committee by October of 2009; and requires all high school coaches to receive and be tested on a sports safety course

HB 414 Identifies the means by which a health maintenance organization, state government, or pharmacy benefits manager may audit pharmacies

HB 489 Establishes rules for courts in establishing child medical support guidelines in divorce cases //2010//

Capacity - Division of Maternal & Child Health (formerly Adult and Child Health Improvement)

The Division of Maternal and Child Health is located within the Department for Public Health. Steve Davis, M.D., led the Division for 11 years, then was appointed Deputy Commissioner of the Department for Public Health.

Ruth Ann Shepherd, M.D., F.A.A.P. became Title V Director and the Director of the Division of Maternal and Child Health Improvement in September 2005.

The Division of Adult and Child Health Improvement, now Maternal & Child Health was comprised of five branches; Maternal and Child Health, Chronic Disease Prevention and Control, Nutrition Services, Health Care Access, and Early Childhood Development. In April 2007, a reorganization moved the Chronic Disease and Health Care Access branches to a new divison of Prevention and Quality Improvement. This included Tobacco Control, Diabetes, Arthritis, Osteoporosis, Comprehensive Cancer. Physical Activity, and Obesity prevention; however, there remain close working relationships between these programs and the MCH staff. This change returned the ACHI Division to its original and primary focus on maternal and child health issues, including 3 branches as described below: Maternal and Child Health, Nutrition Services and Early Childhood Development. The Oral Health section was moved to Maternal and Child Health.

/2009/ Effective June 16, 2008, the Division of Adult and Child Health Improvement is officially the Division of Maternal and Child Health. //2009//

Early Childhood Development Branch
The Early Childhood Development (ECD) Branch provides active leadership in achieving the health goals of the state's early childhood initiatives and implements statewide services for preventive health in very young children, education to the caretakers of those very young children and direct interventions to children identified as needing developmental and/or social and emotional services. This branch promotes coordination and collaboration between the three major birth to age three programs in the state for both children with and without developmental concerns.

The Branch has three sections, Early Childhood Promotion, Early Childhood Intervention and Newborn Screening & Genetic Services. The Early Childhood Promotion Section is comprised of three initiatives that were included in the early childhood legislation, KIDS NOW, that was unanimously passed in 2000 -- HANDS, Healthy Start in Childcare, and Early Childhood Mental Health. In addition, that section administers the ECCS Grant. The Early Childhood Intervention Section includes First Steps, Kentucky's Early Intervention System (Part C) for children birth to age three who have a suspected developmental delay or a medical condition known to cause a developmental delay. The Part C Program was moved to the Department for Public Health in 2004. The NBN Screen &Genetic Services section is home for the Expanded Newborn Metabolic Screening Program, Metabolic Foods and Formula Program, the Kentucky Birth Surveillance Registry, State-wide Genetics and Diagnostic Services. The Kentucky Birth Surveillance Registry provides critical data and information regarding children birth to five with

birth defects The Early Childhood Development Branch will also administer the State Systems Development Initiative (SSDI) grant effective June 1, 2006.

Child and Family Health Improvement Branch
This branch was called the Maternal and Child Health Branch before the reorg in June 2008 as it contains many of the traditional MCH programs. It functions with three main sections: Perinatal Health, the Oral Health Section and the Pediatric Section. The Pediatrics Section includes child preventive health screenings (Well Child and EPSDT), School Health, Child Lead Poisoning Prevention, Child Fatality Review and Injury Prevention program, the Coordinated School Health Initiatives, and EPSDT Outreach. The branch assures quality programs in all areas of MCH programming and policy through coordination, collaboration and technical assistance to partners throughout the state.

The Oral Health Section works continuously to make medical professionals as well as non-professionals aware of the linkages of oral health with general health (i.e., diabetes, heart disease, preterm low birth weight babies, early childhood caries, and others) through disease prevention and health promotion activities including fluoride varnish, dental sealants, surveillance, and mobile dental clinics. The vision is that oral health is integral to general health and most oral diseases are highly preventable using evidence-based approaches. Oral Health initiatives also target pregnant women and the links to preterm birth.

The state dental director has a new partnership with the Kentucky Chapter of the American Academy of Pediatrics to implement a grant from the national AAP. Kentucky members (pediatricians) participate in a pedodontist-moderated webcast regarding oral development, conditions and disease processes with an emphasis on early childhood caries. Dr. McKee followed up with webcast participants with a "Lunch and Learn" event that reviewed the highlights of the webcast and did hands-on training and demonstration/return demonstration on fluoride varnish application on the very young patient. These training opportunities included pediatricians and nursing staff and were held in the pediatric offices throughout the state.

Nutrition Services Branch
The Nutrition Services Branch includes the Nutrition Program, WIC Program, 5 A Day Program, and the Farmers' Market Nutrition Program (FMNP) in collaboration with the Kentucky Department of Agriculture. The federally funded WIC Program sets the standards for nutrition services. WIC's primary focus is to provide nutritious foods, nutrition education and, when appropriate, breastfeeding information and appropriate social and medical referrals for low-income pregnant, breastfeeding and postpartum women, infants, and children who are at nutritional risk. The program is also responsible for promoting breastfeeding, resulting in 31% of low-income women breastfeeding.

The Nutrition Services Branch, in collaboration with the Department of Agriculture, administers the WIC Farmers' Market Nutrition Program (FMNP). FMNP provides participants in the WIC Program with coupons to purchase fresh fruits and vegetables at local farmers' markets. Through this program, WIC participants receive the nutritional benefits of fresh fruits and vegetables and nutrition education concerning 5 A Day. Forty-one (41) local agencies/sites, approximately 23,313 WIC participants and approximately 600 farmers received the benefits of this Program.

The Medical Nutrition Therapy program provides medical nutrition therapy to eligible clients in 120 counties and community nutrition education services to all counties. Each local health department must assure the services of a Registered Dietitian for referring clients who need medical nutrition therapy. The Program goals are to; promote healthy eating that follows national guidance policy, impact policy that improves access to healthy foods, and promote healthy weight among adults and children. Besides providing medical nutrition therapy to patients with problems such as obesity, diabetes and cardiovascular disease, nutritionists conduct in-service education for staff. The community programs use proven strategies such as the 5 A Day Program, Choose 1% or Less Program, weight loss classes, cooking classes, and menus for day care centers and

schools.

The Kentucky WIC program has been innovative in moving to electronic formats for everything from vendor management to the breastfeeding peer counselors tracking and reporting. The WIC Program applied for and was awarded a $1.5 Million USDA grant to develop and pilot an on-line, integrated EBT system in 2 counties. The Program will design, develop and implement a WIC integrated system for up to 4 corporate retailers as well as other retailers in the pilot counties. The WIC Program also applied for and was awarded a USDA Infrastructure Grant to design a web based Management Evaluation system. ***/2010/ The KY WIC EBT pilot will be launched in summer 2009 and will include integrated systems will major vendors such as Walmart. //2010//***

Capacity: Division of Women's Health
This Division was created in the reorganization to absorb the Office of Women's Health that was housed elsewhere in the cabinet, as well as the DPH women's health programs. This Division focuses on promotion of women's health, as well as clinical services and prevention education. Programs include the Women's Breast and Cervical Cancer program, Title X/Family Planning services including Folic Acid supplementation and counseling and Sexual Violence Prevention and Education program, Adolescent Health, Abstinence and pregnancy prevention and Positive Youth Development programs. The Division is responsible for the Sexual Assault Prevention and Education Grant, but partners with the Dept for Community Based Services for its implementation. Dr. Ruth Ann Shepherd, is the acting Division Director. Joy Hoskins, RN, former lead of the Title X program and Section Supervisor for the Women's Health Section, is the Assistant Director.
/2010/ Dr. Connie White was appointed Division Director in March, 2009. Joy Hoskins is now the Assistant Chief Nurse for DPH and the division's assistant director has not been named. //2010//

/2009/The Kentucky Women's Cancer Screening program has accomplished improvements in the data system that have allowed us to meet all of CDC's 11 data indicators for the program consistently for 6 quarters. The program continues intensive outreach to women who are rarely or never screened.

The Division has taken over the Breast Cancer Trust Fund, a legislated fund for education, outreach, and research for breast cancer. The funds are adquired thru sale of a breast cancer license plate and from a check-off on the Kentucky income tax forms. Proposals are submitted annually and reviewed by an independent panel for funding.

With technical assistance from the HRSA Office of Women's Health, this division is currently developing a proposal to establish an Office of Minority Health in Kentucky.

The Division is also working collaboratively with the Kentucky Commission on Women. The current Director of that office is Eleanor Jordan, a former state representative and previously an ombudsman for the Cabinet for Health and Family Services. She has chosen women's health as her priority topic for advocacy and education.

Effective June 16, 2008, the Division of Women's Physical and Mental Health was shortened to be called the Division of Women's Health. The programs and services remain the same. //2009//

Capacity: Local Health Departments

The coordination and cooperation between DPH and local health departments cannot be overstated. KY has 16 district health departments and 40 independent health departments providing health care services to 120 counties. Local health departments are the primary prevention presence for maternal and child health services in Kentucky. Traditionally, this has meant that most of the Title V Block Grant funds have supported the direct clinical and preventive

services in the local health departments. The Public Health Practice Reference (PHPR), developed by DPH, serves as the guidance for clinically based information to support patient-centered health care in the local health departments and compentency training is arranged on TRAIN. DPH Management holds monthly meetings with LHD Administrators.

/2010/ Capacity: Commission for Children with Special Health Care Needs

Despite challenging economic times, the Commission maintains a strong commitment to enhancing the quality of life for Kentucky's children with special health care needs through direct service, leadership, education and collaboration. Services are provided in 12 offices throughout the state, which are 2 fewer than historically operated. In June of 2008, the agency closed the office which served families in Northern Kentucky. In January 2009, the patients served and services provided by the Hopkinsville office were merged with those of the office located in Bowling Green. The closure of the office in Northern Kentucky was accomplished with regard for the continuation of health care services for those families. An information letter was mailed to every family enrolled in Commission services. Families have been given the opportunity to continue their existing services with providers in their home area, although case management was reassigned to the Louisville, Lexington or Morehead office. The majority of families have chosen to have their case coordinated through the Lexington office. In 2009, new agency policy is expected to be written, which will define geographic boundaries and requirements for travel to a physical Commission location.

Direct medical services are provided to children with certain conditions, both congenital and acquired. See locations of regional offices and list of conditions treated by the Commission at http://chs.ky.gov/commissionkids/clinics.htm. The Commission provides family-centered, community-based care by sending treatment teams including nurses and pediatric specialty physicians at clinic sites throughout the state. Clinics for specific complex conditions that require multi-disciplinary treatment teams are held only in Louisville and Lexington due to availability of providers. Families in need receive financial support to assist with travel and/or lodging in order to attend these clinics or receive hospital services.

The Commission maintains a local provider network through contracts with approximately 950 contract physicians (including 109 pediatricians and 177 dentists). Other medical and ancillary services e.g., therapists, pharmacists, audiologists are available through contracts with local community providers. The Commission also contracts with foreign and sign-language interpretative services to assure access to care for families of diverse cultures including those with hearing impairments. These services are available in each Commission region. A need for interpretative services is identified during intake and arrangements are made for appropriate service prior to clinic or other Commission appointments. The Commission continues to look for cost-effective, yet qualified, interpreter resources as the cost of interpretation continues to rise. All Spanish interpreters must be deemed qualified by CHFS and all sign-language interpreters must be licensed through the Board of Interpreters. Employees who are already employed by CHFS and also deemed qualified to intepret are of no additional charge, but their schedules frequently make them unavailable.

A Memorandum of Agreement between the Commission and the State Division of Disability Services assures that children who apply for SSI benefits receive referral and outreach services.

The Commission holds an MOU with the Department for Community Based Services (DCBS) to provide nursing consultative services to children in the foster care system. Consultation to the DCBS social workers and foster care families includes discussion of medical issues, interpreting medical records and reports, assuring updated medical

passports and enhancing care coordination of all services.

The Commission supports and encourages process development with the recommendations of parents of and children with special health care needs. In addition to two parent consultants who are on staff, the agency coordinates a Youth Advisory Council which meets on a quarterly basis and provides an opportunity for children with special health care needs to collaborate with other youth, discuss pertinent issues, express needs to Commission staff and become empowered in the management of their own health care. As well, the Parent Advisory Council meets on a quarterly basis and provides the same opportunity for parents of children with special health care needs. Council members are provided assistance with their travel, food expenses and lodging.

In 2009, the Commission was notified that funding will be recommended as part of the Family 2 Family (F2F) grant. This funding will provide parent consultants the ability to coordinate family partnerships throughout the state. Although the partnerships will be voluntary, the Commission will provide assistance with travel and lodging as needed. This new family mentorship program will provide a gateway for information-sharing between families, and will allow them to maximize their existing community resources.

The Commission is expanding the capacity of its health information system to fully support the core functions of public health as relates to children and youth with special health care needs (CYSHCN): to assure early identification and screening leading to diagnosis, treatment, and access to community-based systems of care; to provide comprehensive care coordination with the context of the medical home; to identify and eliminate disparities in health status outcomes; and to support program accountability through the collection, analysis, and reporting of data and progress in meeting performance targets.

The electronic patient data collection system (CUP) allows staff to enter patient information directly into a system designed to serve as an electronic medical record. Information pertaining to the demographic, diagnostic, treatment, medication, insurance, and transition history for each patient is maintained in a password-protected system on a secure network. This system is designed with future expansion and accommodation of agency needs in mind. Most recently, enhancements were made which enable newborn hearing screening information to be electronically transferred, whereas, in the past, agency staff was manually entering each newborn hearing screen report. Current plans will allow the agency to electronically collect follow-up audiological information; thus reducing the number of children who are lost to follow-up.

An electronic provider dictation/transcription system has also been created. Although the roll-out of this system has been delayed, it is anticipated that the agency will proceed with its implementation in the next year.

Administratively, the Commission began the process of reviewing and updating all agency policies in 2008. Updated policies will ensure that all procedures (clinical and administrative) are current, easily understood and readily accessible on the agency Intranet site by all staff. As well, patient chart audits are conducted on a regular basis by the Nurse Service Administrators to ensure that appropriate documentation is completed in a timely manner. //2010//

/2008/ Capacity: Special Projects

Data Mini-Grant: The Department for Public Health received an AMCHP CDC Data Mini-grant. A one-day workshop was conducted by faculty from the University of Kentucky, College of Public Health in May 2007. The goal of the workshop was to increase the epidemiology capacity and enhance the skills of staff in accessing and using existing data for planning and evaluating public

health interventions and programs.

/2010/ Kentucky received a State Data and Assessment Technical Assistance (DATA) mini-grant from the Association of Maternal and Child Health Programs in 2009. These grant funds were used to complete a two-day skill building workshop for data analytic and lead program staff. The goal of the workshop was to increase the knowledge of staff on planning, evaluating and revising maternal and child health programs using cost effectiveness and cost benefit analyses. The training objectives were to:
•understand the necessary components of a cost benefit or cost effectiveness analysis;
•understand how the choice of a discount rate affects costs;
•understand how the value of life is estimated (including quality-adjusted life years and disability-adjusted life years);
•understand the role of uncertainty in these analyses; and
•understand how to apply these concepts to actual programs.

The first training day (April 13, 2009) focused on didactic training on the application of cost effectiveness and cost benefit analyses to maternal and child health programs. An overview of Kentucky's home visitation program, HANDS was also provided so that the participants could discuss how to conduct a cost analysis for an existing program. The second day of the training (May 6, 2009) focused on utilizing the skills taught in the first session with the HANDS program. Evaluation of the training will be completed by August 2009.

The trainings were provided by Dr. Scott Hankins, an Assistant Professor with the College of Public Health at the University of Kentucky. He holds a Ph.D. in Economics from the University of Florida. His research investigates factors that affect neonatal health. He currently is studying the effect of state regulations (both insurance and hospitals) on neonatal health outcomes. He is also interested in how obstetricians respond to medical malpractice lawsuits. In addition to the skill building from the training, an important outcome from this mini-grant has been the opportunity to build a collaborative relationship with an expert who may provide additional guidance to maternal and child health programs in the future. //2010//

CDC Epi Assignee: The Department for Public Health has applied and been approved for a CDC Epidemiology Assignee. Dr. Sarojini Kanotra will be the assignee for Kentucky. Dr. Kanotra has had extensive training and experience in maternal and child health, and has served as a guest researcher with CDC as well as an evaluation consultant with the Georgia Department of Health. Her areas of expertise include PRAMS, Perinatal Periods of Risk, and FIMR. Dr. Kanotra previously was the Epidemiologist/Evaluator for the Healthy Start Program in Louisville. /2009/ Although it was expected that a Centers for Disease Control and Prevention (CDC) Senior MCH Epidemiologist assignee was going to be assigned to Kentucky, this has not occurred to date.***/2010/ Dr. Kanotra joined DPH in September 2008.//2010//***

HRSA Graduate Student Intern: A graduate student intern was matched thru HRSA's program to help DPH undertake a PRAMS pilot project in Kentucky. Ayana Anderson completed her MPH at UK and has been working with DPH through the HRSA Graduate Summer Intern Program. Ms Anderson has been the lead in the development of a PRAMS pilot project that KY plans to begin in Fall 2007.
/2009/ Ms. Anderson began full time with the Kentucky Department for Public Health on March 1, 2008. //2009//
/2010/ Ms. Anderson was selected for a position with the CDC, beginning in May, 2009. //2010//

MCH Institute: Kentucky is a state with many maternal and child health problems, but currently no training programs that specifically develop public health expertise in maternal and child health. With the support of Dr. Steve Wyatt, Dean of the UK College of Public Health, DPH has

contracted with the University of Kentucky, College of Public Health to develop and administer the MCH Institute to increase Kentucky's capacity to address MCH performance and outcome measures. The initial goal is to set up a certificate program for current public health professionals who are working in or interested in furthering their knowledge of MCH. Dr. Jim Cecil, former DPH Oral Health Director, will be the MCH Institute Director. ***/2010/ The Graduate Certificate in Maternal and Child Health was approved by the Faculty Senate in May 2009 and the Certificate will be offered in the Fall Semester 2009. As of May 29th, 2009 one student is enrolled and two other students are making application for the Fall Semester. We expect more students will apply for the Spring Semester and beyond. An Advisory Committee meeting is being scheduled for mid June 2009 to update the Committee and gather information about the concerns of the Committee.***

In mid May 2009, the University of Alabama Birmingham was awarded a $900K HRSA MCH training grant over five years to develop and implement a Graduate Certificate in MCH whose course content will be delivered by use of the internet only to health care workers who are admitted to the Certificate Program. The UK College of Public Health is a major collaborator in this grant and will receive about $72K per year for five years to cover the collaboration expenses. Since it's award, the PI from UAB has accepted a position at the University of Arizona and is now in the process of transferring the grant to the U of Arizona. The funding date for the HRSA grant is June 1, 2009, with several collaborator meetings scheduled in Nashville (August and November) in 2009. //2010//

C. Organizational Structure

Office of the Governor

Kentucky elected a new Governor in November 2007. Steven L. Beshear took the Oath of Office in December 2007. Governor Beshear has a B.S. and a law degree from the University of Kentucky. He has spent his life serving Kentucky in the US Army Reserves, as a State Representative, Attorney General, and Lt. Governor prior to his election. As a state legislator in the 70's, with the assistance of his brother, who is a pediatrician, Mr. Beshear led the legislature to the establishment of Kentucky's system of Regionalized Perinatal Care.

Lt. Governor Daniel Mongiardo is a physician and surgeon serving in his home area of Eastern Kentucky. He received his B.S. from Transylvania University and his medical degree from the University of Kentucky School of Medicine. Prior to his election, Lt. Governor Mongiardo was also a State Senator.

Cabinet for Health and Family Services -- Provision of Health in Kentucky

In Dec. 2003, The Cabinet for Health Services and the Cabinet for Families and Children were consolidated into a single cabinet called The Cabinet for Health and Family Services (CHFS). The Cabinet is divided into four administrative units each lead by an undersecretary. The four units are: Administrative and Fiscal Affairs; Health Services; Human Services; and Children and Family Services.

The Cabinet for Health and Family Services is the state government agency that administers programs to promote the mental and physical health of Kentuckians. The Cabinet includes the following departments: Public Health, Mental Health and Mental Retardation Services, Medicaid Services, Disability Determination Services, Human Support Services and Community Based Services. It also includes the Commission for Children with Special Health Care Needs, and the following offices: Ombudsman, Certificate of Need, Inspector General, Legal Services, Fiscal Services, Human Resource Management, Technology, Contract Oversight and Legislative and Public Affairs. In a reorganization 2006, The Department of Aging and Independent Living, the

Office of Health Policy and the Governor's Office of Wellness and Physical Activity (GOWPA) were created. The Department for Medicaid Services is no longer under the Undersecretary for Health but reports directly to the Cabinet Secretary.

With the change in administration in 2008, Governor Steve Beshear has appointed Janie Miller as Cabinet Secretary and Steve Nunn as Deputy Secretary of the Cabinet for Health and Family Services (CHFS) in January 2008. Miller brings more than 30 years of experience to the position, including 21 years developing and administering health care programs. Her career also includes more than 15 years of service in the former Cabinet for Human Resources. Prior to her appointment as Secretary, Miller held the position of Deputy Director of Budget Review for the Legislative Research Commission (LRC). In this role, she was responsible for assisting legislators in facilitating the development of budget bills for all three branches of government. Secretary Miller holds an undergraduate degree in Social Work from Eastern Kentucky University.

Former State Representative Steve Nunn brings 16 years of experience on the Kentucky House of Representatives' Health and Welfare Committee, including 10 years as vice chair, to the position of Deputy Secretary of CHFS. During his legislative career, Nunn served on numerous legislative subcommittees focusing on the welfare and safety of children and individuals with mentally impairments.
/2010/ Mr. Nunn resigned as Deputy Secretary to CHFS. This position has not been filled. //2010//

Department for Public Health

In November 2004, Dr. William Hacker was appointed Commissioner of the Department for Public Health (DPH). Dr. Hacker had served as acting commissioner for the department since July 2004 upon the retirement of Dr. Rice Leach. Dr. Hacker joined the Department for Public Health as a Physician Consultant in 2001 and served as Branch Manager for the Public Health Preparedness Branch since 2002, where he has headed up the department's disaster preparedness planning efforts. Prior to joining state government, Dr. Hacker's experience included almost 20 years of private medical practice, as well as serving as the Chief Medical Officer of Appalachian Regional Healthcare, Inc. He is Board Certified in Pediatrics and a Certified Physician Executive. He received both undergraduate and medical degrees from the University of Kentucky.

Dr. Hacker continues to serve as the State Health Officer for the Commonwealth, as well as the Commissioner of the Department for Public Health. Dr. Hacker meets quarterly with the Deans from all the Kentucky-based Colleges of Public Health for sharing information, projects, and ideas. He served as a close advisor to Governor Beshear and liason with federal agencies during the natural disasters that occurred in KY in early 2009. The ice storm of 2009 was the worst wintertime natural disaster in the state's history. This was followed by flooding. Then the H1N1 response took everyone's attention. Kentucky's disaster planning and preparation was well tested and many lessons learned; overall performance was commended by federal agencies.

Dr. Steve Davis, Deputy Commissioner of DPH did his undergraduate studies at Morehead State University receiving a Bachelor of Science degree in Biology. He received his M.D. degree from the University of Kentucky and completed his internship and residency in Pediatrics at the University of Kentucky Chandler Medical Center.
He practiced pediatrics in eastern KY before coming to Frankfort in 1996, where he has continued to serve tirelessly on behalf of Kentucky's women and children.
Ruth Ann Shepherd, M.D., F.A.A.P., C.P.H.Q., became the Director of the Division of Adult and Child Health Improvement September 1, 2005.

The Department for Public Health (DPH) is the only agency in Kentucky responsible for developing and operating all public health programs for the people of the Commonwealth. Kentucky Revised Statute 194.030 created DPH to "develop and operate all programs of the cabinet that provide health services and all programs for the prevention, detection, care, and

treatment of physical disability, illness, and disease." Dr. Hacker says "The Department for Public Health is about 400 employees assisting 4000 Health Professionals to care for over 4 million Kentuckians and we touch their lives in some way every day."

The Department for Public Health underwent reorganization in April 2007. Two new Divisions were created and some Branches were realigned. The new Division of Women's Health is described under Agency Capacity. Dr. Ruth Ann Shepherd, Title V Director, is the Acting Division Director in addition to Director of the Division of Adult and Child Health Improvement. DPH is divided among seven divisions described below:

Division of Maternal & Child Health, formerly Adult and Child Health Improvement (ACHI) promotes maternal, child and family health by developing systems of care and by promoting and providing preventive health services to at risk populations.
/2009/When the reorganization became official, in June 2008, the name of this division was changed back to Maternal and Child Health, emphasizing the focus on MCH populations and issues. The Chronic Disease and Health Access sections were moved to the new Division of Prevention and Quality Improvment. //2009//

Division of Women's Health oversees the women's health programs and initiatives in the Department. Their focus is on adolescent, preconcpetion and interconception care, and cancer screening. The Division is described in the Capacity section of this grant.

Division of Epidemiology and Health Policy is responsible for communicable disease prevention (immunization, HIV, TB, STD, etc.) and control, disease surveillance and investigation, adult injury prevention and research, maintenance of vital statistics and health data, including hospital discharge data and county health profiles. This division also publishes various health planning documents including the Kentucky Public Health Improvement Plan and Healthy Kentuckians 2010. This Division is also led by a pediatrician, Dr. Kraig Humbaugh. MCH Programs work closely with this division's programs including emergency preparedness, Immunizations, HIV, Communicable disease, and vital statistics. Vital Statistics has implemented an electronic birth certificate for all birthing hospitals. As the result of collaborative efforts, screens for this data also produce the documentation for newborn metabolic screening and universal newborn hearing screening. Kentucky is currently working on a system for electronic death certificates.

The Division of Laboratory Services provides analysis and quality control for health department laboratories and reference services to laboratories. The central lab also conducts metabolic screening for all newborns in the Kentucky. They identify agents from communicable disease outbreaks, as well as from bioterrorism threats.

The Division of Public Health Protection and Safety protects Kentuckians from unsafe consumer products, lead hazards, radiation and other toxic exposure, unsanitary milk, adulterating and misbranded foods, unsanitary public facilities, and malfunctioning sewage systems.

The Division of Administration and Financial Management develops and oversees the Department for Public Health's budget as well as local health department's fiscal planning, allocations and payments, and their administrative and management practices. The division also manages departmental procurement and contracts, information technology and administrative support to local health departments in all 120 counties of the Commonwealth.

The new division is the Division of Prevention and Quality Improvement assumed responsibility for Chronic Disease Prevention and Control, Health Care Access programs, the Quality Improvement program, department training, and the BRFSS. Dr. Regina Washington is the Division Director. Dr. Washington obtained her BA from Berea College, MA in Health Sciences from Eastern Kentucky University, and a DrPH from the University of Kentucky College of Public Health. She has experience in teaching, rural health program, and cancer screening and prevention.

Division of Maternal and Child Health (Formerly ACHI)

The Division of Maternal and Child Health (MCH) has 3 branches including Nutrition Services, Early Childhood Development and Child & Family Health. These are described in the Capacity section. This division, through the Title V grant and other activities, seeks to provide leadership, in partnership with key stakeholders, to improve the physical, socio-emotional, safety and well-being of the maternal and child health population that includes all of Kentucky's women, infants, children, adolescents and their families. For over 50 years, MCH has provided the foundation for addressing issues related to the overall health of the community. This mission is carried out in collaboration with partner agencies, primarily, local health departments, other state agencies and state universities to increase capacity for clinical and community-based services for the MCH population. At the state level, MCH goals are achieved through policy and program development, special grants, surveillance, consultation, technical assistance, education, training and case management.

/2010/ Commission for Children with Special Health Care Needs

The Commission operates under a streamlined organizational structure. The agency employs an Executive Director, a Deputy Executive Director, Medical Director, 3 Division Directors (and subsequent administrative, support, clinical and therapeutic staff throughout 12 regional offices.

The Division of Administrative Services provides intake, personnel, training, provider relations, billing, financial reporting, and health information services. The Division of Health and Development provides nursing and foster care support services. The agency manages clinical operations under the direction of Nurse Service Administrators, in an East-West division organization. The Division of Quality Outcomes Management provides all therapeutic, transition and parent consultant services; and services through the Early Hearing Detection and Intervention program.

In addition to on-staff parent consultants, the agency incorporates public parent and youth involvement in decisions that impact service delivery. The Parent Advisory Council and Youth Advisory Council are comprised of individuals throughout the state (not just families with children enrolled in Commission services) who hold an interest in children with special health care needs (CSHCN). Each Council meets quarterly at the Commission's Louisville office to discuss pertinent issues, provide training and brainstorm about how the Commission can better serve Kentucky families with CSHCN.

The Commission's Executive Director, Medical Director and Division Directors are appointed by the Governor, as are members of the Board of Commissioners and the Hemophilia Advisory Committee. The Board of Commissioners provides oversight and approval of the Executive Director's actions. The Board meets quarterly with the Executive Director and senior management to review program status, consult and advise on programmatic concerns, and take voting action as required. The Executive Director, with approval of the Board of Commissioners, appoints members of the Medical Advisory Committee. The Early Hearing Detection and Intervention (EHDI) program also operates under the advisement of the EHDI Advisory Board. The Medical Director provides oversight for the children with special health care needs Title V program.

In June 2008, the Commission closed the doors to the office which served families in Northern Kentucky. Shortly thereafter, services and patients of the Hopkinsville office were merged with the office in Bowling Green. These changes were the result of budget constraints. This change decreased the number of statewide regional offices from 14 to 12.

In July 2008, one of the Nurse Service Administrators retired and the vacant position was not filled. Instead, the Central Service Region was eliminated and the agency began clinical operations under an East-West division structure.

Additional changes to the organizational structure are pending approval of a reorganization proposal, which may become effective in July 2009. //2010//

D. Other MCH Capacity

Senior Management

Director, Division of Adult and Child Health Improvement
Ruth Ann Shepherd, M.D., F.A.A.P., C.P.H.Q. was appointed Director of the Division of Adult and Child Health Improvement and began her duties on September 1, 2005. She received her B.A. in Biology/Pre-med from Asbury College, in Wilmore, KY, magna cum laude and her M.D. degree from the University of Louisville School of Medicine. Dr. Shepherd did her residency in Pediatrics at Methodist Hospital Graduate Medical Center in Indianapolis, Indiana and her Neonatology Fellowship at Medical University of South Carolina in Charleston, SC. Dr. Shepherd has Board Certifications from the American Board of Pediatrics and the American Board of Neonatal-Perinatal Medicine. Dr. Shepherd professional experience includes partner in private practice in Neonatology and General Pediatrics in Louisville, KY and then became Director of Neonatology Services at Pikeville Methodist Hospital, a Regional Level II+/3A Neonatal Intensive Care Unit with Regional Neonatal Transport Service, Infant Apnea Program, Neonatal Developmental Follow-Up Clinic, and Early Intervention System 0-3 Intensive Evaluation Team, and Medical Advisor to the Infant Hearing Screening Program. Dr. Shepherd is on the Board of the Greater Kentucky Chapter March of Dimes and the Kentucky Perinatal Association.
/2008/ Dr. Shepherd is also currently the Acting Division Director for the Division of Women's Health.
/2009/ Dr. Shepherd has presented on behalf of Kentucky at the American Public Health Association, the National Center for Health Statistics, and the Surgeon General's Conference on Preterm Birth. She is currently serving on the National Quality Forum Steering Committee for Perinatal Indicators. //2009//

Assistant Director, Division of Adult and Child Health Improvement
Marvin Miller, MSW, is the Assistant Director for this Division. Mr. Miller has worked in public health for over thirty years, and has been assistant director in Maternal & Child Health for over 20 years. Mr. Miller has been instrumental in the development of our WIC program, Well Child Program, and others. A few of his accomplishments include the establishment of EPSDT outreach, a child safety seat program, and our HANDS home visiting program. Some of Mr. Miller's current functions include legislative liaison for the Division, and oversight of the local health department's plan and budget process.

/2010/ Director, Division of Women's Health
Connie Gayle White M.D. was appointed the Director of the Division of Women's Health in March, 2009, joining the division after practicing obstetrician/gynecologist for over 20 years in Frankfort, Kentucky. She is a graduate of Kentucky Wesleyan College with a Bachelor of Science in Chemistry. She received a Master of Science in Toxicology and worked as a researcher in Teratology at the National Center for Toxicological Research in Little Rock, Arkansas. She later attended medical school at the University of Kentucky. She completed her OB-GYN residency program at the University of Louisville. She is board certified in OB/GYN by the American Board of Obstetrics and Gynecology with a special emphasis of her work on patient education and preventive medical care.

Dr. White's professional activities include the Board of Trustees Frankfort Regional Medical Center (chair 2007-2008), American College of OB/GYN (ACOG), and ACOG-Kentucky Section (Chair 2007-2010, Vice President 2006, Secretary/Treasurer 2004-2006). She has been active on the Planned Parenthood of the Bluegrass Board of Directors, Frankfort United Way, Frankfort Arts Foundation and Medicaid Therapeutics Advisory Committee and many others. //2010//

Assistant Director, Division of Women's Health
Joy Hoskins, RN, BA, is the Assistant Director for Women's Health. //2008//
/2010/ Ms. Hoskins is currently serving as the Assistant Director of Nursing for DPH. The Assistant Division Director has not been named. //2010//

Branch Manager, Maternal and Child Health
Leading this branch since September of 2002, Linda Lancaster has been with the DPH since 1988; working with Kentucky's Early Intervention Program (First Steps), Kentucky's Birth Surveillance Registry, State Folic Acid Supplementation Program, Adult Preventive and Arthritis programs.
/2010/ Linda Lancaster retired from DPH in December 2008. On March 1, 2009, Shelley Adams became the Branch Manager of Child and Family Health Improvement. Ms. Adams came to Public Health from the Department for Medicaid Services after 4 years working primarily with community mental health and waiver programs as a Nurse Consultant Inspector, then as a branch manager in Community Alternatives. Ms. Adams has a Bachelor of Science in Nursing from Northeast Louisiana University and a Master of Science in Nursing from the University of Phoenix. //2010//

Branch Manager, Nutrition Services
Frances M. Hawkins manages the Nutrition Services Branch. Ms. Hawkins coordinates the Nutrition Services Branch, which administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Adult and Child Health (ACH) Nutrition Program, the Five A Day Program, the Farmers' Market Nutrition Program (FMNP) in collaboration with the Kentucky Department of Agriculture and the Obesity Component of the Centers' for Disease Control Chronic Disease Prevention and Health Promotion Programs Grant. Ms. Hawkins received her training at Indiana University of Pennsylvania and her Master's degree at the University of Kentucky. She has managed the Nutrition Services Branch since 1996 and is a registered, licensed dietitian.

Branch Manager, Early Childhood Development Branch
Effective August 1, 2005, Joyce Robl became the Branch Manager of the Early Childhood Development Branch.
Joyce Robl returned to the University of Kentucky to complete her Doctoral degree. She continues to lend her expertise to the Early Childhood Branch on a part-time basis. She was replaced by Jennifer O'Brien was named the Branch Manager of the Early Childhood Branch in October 2007. ***/2010/ Ms. O'Brien transferred to the Department for Mental Health, Developmental Disabilities and Addiction Services. The position has not yet been filled. //2010//***

Other Key Program Staff
/2010/ Dr. Torrie T. Harris became the first Director of the Office of Health Equity in the Kentucky Dept for Public Health in December 2009. She is an Assistant Professor in the Health Systems Management department of the UK College of Public Health. She received her Dr.P.H. from the UK College of Public Health in Health Behavior. Prior to coming to UK, she received her Masters of Public Health at Tulane University School of Public Health and Tropical Medicine with a concentration in Maternal and Child Health Care. Dr. Harris worked extensively on maternal and child health programs studying infant mortality and morbidity, child passenger safety, minority health, and public mental health. Dr. Harris is particularly interested in access to healthcare of disadvantaged populations

and the implications on behavioral health, public health systems and services research, adolescent health and mental health policy.//2010//

Title V Administrator
Gwen Cobb is the Title V Administrator and Pediatric Section Supervisor in the MCH Branch. /2009/ Ms. Cobb retired July 31, 2008. Her replacement has not been named. //2009//

State Dental Director
/2009/ Dr. Julie McKee was named the State Dental Director in September 2007. Dr. McKee has a BS in Biology from the University of Kentucky and her DMD from the University of Louisville. Prior to her appointment, Dr. McKee was the Director of the Wedco District Health Department for over 12 years. //2009//

MCH Epidemologist
Tracey D. Jewell is the lead maternal and child epidemiologist for the MCH Branch. Ms. Jewell earned her Master's of Public Health at the University of Alabama Birmingham School of Public Health in 1998. She joined the staff at the DPH in February of 1999 and came to the MCH Branch in January of 2001 to assume her present position.
Effective September 1, 2005, Ms. Jewell was promoted to Lead Epidemiologist for the Division of Adult and Child Health Improvement. Ms. Jewell is involved in all ACHI and MCH Epi efforts.

/2008/ CDC MCH Epidemiology Assignee
The Department for Public Health has applied and been approved for a CDC Epidemiology Assignee. Sarojini Kanotra holds a Master's in Public Health from Emory University and Master's and Doctorate degrees in Microbiology from the Indian Agricultural Research Institute in New Delhi, India. Dr. Kanotra is a Certified Health Education Specialist and is a member of numerous professional organizations including the American College of Epidemiology, the American Public Health Association, the Council for State and Territorial Epidemiologists and the Society for Public Health Education. Dr. Kanotra has been a guest researcher at the CDC and an Evaluation Consultant with the Georgia Department of Health. She has experience with PRAMS, PPOR, and FIMR, and has presented her work at the MCH Epi Conference and CityMatch Conference. ***/2010/ Dr. Kanotra joined DPH as a CDC assignee in September 2008. She will be leading the data collection and analysis for the 2010 Title V Needs Assessment.//2010//***

/2009/ Ms. Ayana Anderson began as a full time Epidemiologist with the Kentucky Department for Public Health on March 1, 2008. Ms. Anderson completed her MPH at UK and originally began working with DPH through the HRSA Graduate Summer Intern Program from May to August 2007. As a graduate student intern, Ms. Anderson was matched thru HRSA's program to help DPH undertake a PRAMS pilot project in Kentucky. Ms Anderson took the lead in the development and implementation of the PRAMS pilot project that began in Fall 2007. Ms. Anderson has been analysing the PRAMS data since March 2008 and will oversee a second pilot of the PRAMS program. ***/2010/ Ms. Anderson did get a second PRAMS cycle going, but now has taken a position with the CDC in Altanta. She is now a Public Health Analyst with the Agency for Toxic Substances and Disease Registry.//2010//***

/2010/ A new Program Coordinator to the Child Fatality Review Program was hired February 1, 2009. Amy Sepulveda joined the Child and Family Health Improvement Branch, transferring from the Kentucky State Laboratory, Public Health Lab where she began her Public Health career in June 2008. Amy completed her Bachelors degree in Criminal Justice from Indiana University in 2007 while working full-time at the Marion County Sheriff's Department in Indianapolis, Indiana. //2010//

Commission for Children with Special Health Care Needs - Senior Management Staff

/2010/ In 2008, the Commonwealth of Kentucky experienced widespread retirement of its most experienced and senior staff as the result of a designated retirement window

preceding sweeping changes to legislatively mandated retirement benefits. The Commission for Children with Special Health Care Needs was no exception. Further changes are pending an agency re-organization, which is anticipated to be effective in July 2009.

Executive Director -- In September 2008, Rebecca J. Cecil, R. Ph., was appointed as Executive Director by Governor Steve Beshear. Ms. Cecil brings more than 20 years of experience to the position, including serving as the Commission's Director of Health and Development for 3 years. Before coming to the Commission, Ms. Cecil served as Deputy Undersecretary for Health, Acting Commissioner of Mental Health and Retardation Services, and Director of Licensing and Regulation with the Office of Inspector General. Ms.Cecil is a 1979 distinguished graduate of the University of Kentucky's College of Pharmacy.

Ms. Cecil follows Eric Friedlander, who served as Executive Director from June 2000 to April 2008. Mr. Friedlander's previous experience includes serving as manager of the statewide Family Resource and Youth Services Centers program and as manger of the Budget and Policy Branch of the Office of Program Support for the Cabinet for Health Services. Mr. Friedlander is a graduate of Antioch College with a BS in Economics.

Deputy Executive Director -- Carolyn Robbins, MSN, has served as Deputy Executive Director since July 2008. Ms. Robbins has 18 years of experience in public health, including well-child clinics, family planning, immunization, foreign travel clinic, prenatal clinics and Kentucky's early intervention program (First Steps). She has served as manager of 3 health department clinics in Jefferson County and has overseen services in Neighborhood Place clinics. She has served as State Coordinator of the injury prevention program and the State Safekids coalition, Chair of the Child Fatality Program, and Coordinator of Healthy Start in Child Care. She assisted with the creation of the first Kentucky Fetal Infant Mortality Review program. She continues to serve on the state Child Fatality Review Team and Booster Seat Coalition. Ms. Robbins is a graduate of Bellarmine University with a BSN and MSN.

Medical Director --Richard McChane, MD, has served as the Commission's Medical Director since March 2007. Dr. McChane is also the Medical Director of the Home of the Innocents, serves as a developmental pediatrician at the University of Louisville Weisskopf Child Evaluation Center, and is a faculty member with the University of Louisville School of Medicine -- Department of Pediatrics.

Director of the Division of Administrative Services- Shelley Meredith, CPA, was appointed to this position in October 2008, following the retirement of Kevin Mudd, CPA. Ms. Meredith has over 22 years experience with state government, 19 of which have been with the Cabinet for Health and Family Services in the health care arena. She played a key role in the establishment and development of the Commission's health information system and electronic patient record and is now responsible for managing all the operational functions of the Commission including budgets, contracts, purchasing, accounts payable and receivables, health information and technology, personnel, and MCH Block Grant reporting. Ms. Meredith is a 1985 graduate of the University of Kentucky with a BS in Accounting and a minor in Economics.

Title V MCH Block Grant Author -- Stephanie Mitchell was selected to write the 2010 Application for the Commission following the retirement of Susan Cole, CPA, in July 2008. Ms. Mitchell joined the Commission in September 2000. She has 12 years of experience working for the Cabinet for Health and Family Services, including the Department for Disability Determinations and Department for Public Health. Ms. Mitchell is a 1997 graduate of Transylvania University where she earned a dual BA in Business Administration and Sociology.

Director of Health and Development -- Carolyn Robbins, Deputy Executive Director, is serving as the Acting Director of Health and Development. This position was previously held by Rebecca Cecil, who was appointed as the Executive Director in September 2008.

Director of Quality Assurance -- Anne Swinford was appointed to this position in March 2005. Ms. Swinford's previous experience includes the provision of direct care services to the special needs population, and serving as the Acting Part C Coordinator and Supervisor of Kentucky's early intervention program (First Steps). Ms. Swinford is a graduate of Briscia University and Purdue University, where she earned a BA in Speech and Hearing and a MS in Speech Pathology.

Parent Consultants -- Linda Miller, parent/education liaison, retired in December 2008. Her position has not been filled. The Commission continues to employ two parent consultants who work tirelessly to assist our families in many areas of need, including coordination of community services, advocacy training, technology and policy.

Debbie Gilbert has been with the Commission since November 2005 and works in our Louisville office. Ms. Gilbert is the parent of two children, the second of whom was born with a special health care need. She has been a member of Family Voices since 2000, and currently serves as the State Coordinator. She has also served on the Kentucky Council on Development Disability and has attended Partner-in-Policymaking advocacy training. Ms. Gilbert also has experience as office manager for a busy pediatrician's office. She is a graduate of Spencerian College with a degree in Medical Assistance-Secretary.

Sondra Gilbert has been with the Commission since March 2008 and works in the Owensboro office. Ms. Gilbert has three children who have been diagnosed with a special health care need. Ms. Gilbert has participated in the Pritchard Committee for Parent Leadership, which trains parents to work effectively with the school system, and has volunteered in the Owensboro school system for 16 years. She currently serves on the Regional Inter-Agency Transition Team and has served on the Site Based Decision Making Council. //2010//

E. State Agency Coordination

/2010/ Collaboration - Commission for Children with Special Health Care Needs

The Commission coordinates an MOA with the Department for Medicaid Services that enables the agency to provide therapeutic remedial services for applicable Medicaid eligible children enrolled for Title V/CSHCN services This agreement references the applicable federal and state statutes or regulations and assure that services are provided in accordance with the Title XIX State Plan and EPSDT special services as required by OBRA 89. In 2009, this was updated to an electronic format.

The Commission also operates under an MOU with the Department for Community Based Services (DCBS) and is providing nursing consultative services in 8 of the 9 DCBS regions for children in the foster care system. This program was initiated in February 2005 to provide services for children who are medically fragile. It was expanded statewide in July 2006 to include the entire foster care population. The Nurse Consultants who work with this program provide consultation to the DCBS social workers and foster care families on medical issues, interpret medical records and reports, assure updated medical passports and enhance care coordination of all services. In November 2007, it was further expanded in a collaborative effort with the University of Kentucky to open the Medical Home for Coordinated Pediatrics in the Lexington office, which serves children in the central region of the state.

The Early Hearing Detection and Intervention (EHDI) program maintains many

relationships in the administration of Kentucky's legislatively mandated newborn hearing screening program. In addition to the partnerships with the state's birthing hospitals, the program collaborates with the Commission on the Deaf and Hard of Hearing and Hands and Voices. Since 2006, a partnership with the Office of Information Technology (OIT) has allowed the program to receive newborn hearing screening results electronically through the KY-CHILD database. Ongoing efforts at this time include work with OIT to expand online data transmission to include the ability of community audiologists and early interventionists to electronically transmit diagnostic assessment results and early intervention service notes to the EHDI program. Additional efforts are focused on working with Part C leaders to further implement Early Intervention services that more effectively meet the specific needs of newborns diagnosed with permanent hearing loss. In March 2009, Governor Beshear signed HB 5 which requires audiology diagnostic sites who wish to be included as approved centers for pediatric audiological testing agree to meet specific requirements, including best practice standards and reporting to the EHDI program.

An agency partnership with Home of the Innocents allows Louisville therapeutic staff (PT, OT, SLP) to reside and provide services at the Home of the Innocents facility. This arrangement allows Commission patients and staff to utilize the advantages of a new facility that is closer to the downtown area & medical complexes. The Commission and the Home of the Innocents continue to explore future opportunities for partnership.

The Commission maintains numerous additional relationships with other state agencies. Programs with which our agency collaborates include: First Steps (Kentucky's Early Intervention Program), Special Needs Adoption Program, University of Kentucky, University of Louisville, Eastern Kentucky University, Owensboro Community Technical College System, local health departments, Family Resource Youth Service Centers, Regional Interagency Transition Teams (RITT), State Early Childhood Transition Committee, KIDS NOW, and the state Child Fatality Review Program. Agency association with these entities allows us to further develop goals for the agency, provide community training, streamline services for children with special health care needs in their community and schools, as well as prepare children for the transition into adult health care. //2010//

Collaboration - Local Health Departments

Kentucky has a statewide network of 56 local and district health departments with clinics in 120 counties, that serve as the Department for Public Health (DPH) "service arms". Each local health department are quasi-governmental agencies and each operates under the Kentucky Public Health Practice Reference (PHPR) standards of care for the delivery of all clinical services. All encounter service data for the 120 local health departments is captured through a single data system. This allows for complete review and analysis of services rendered in the local health departments.

DPH has developed the capacity to connect to a tele-health network across the state, through satellite webcasts and videoconferencing. The network includes hospitals and local health departments and is used for training, state-wide educational meetings for public health nurses and other programs.

Collaboration: Department for Medicaid Services

The Division of Adult and Child Health Improvement, as the state Title V agent, has a long history of working cooperatively with the Dept for Medicaid Services. Kentucky's CHIP program (KCHIP) is also coordinated through this department as is KenPAC, Kentucky's Managed Care Program. This relationship continues through several Interagency Agreements (Memorandum of Agreement) that are renewed annually and are listed below:

Preventive health services delivered to Medicaid recipients by local health departments and reimbursed by the Dept for Medicaid Services. /2009/ Flouride Varnish reimbursement was recently approved to be included in the Preventive Health package. //2009// ***/2010/ Flouride varnish has been approved for reimbursement to pediatricians in their offices. This should promote wide utilization of fluoride varnish.//2010//***

Medicaid reimbursement for early intervention services for infants and toddlers who are determined eligible for First Steps, Kentucky's Early Intervention System, authorized by the Individuals with Disabilities Education Act.

Medicaid coverage for home visiting services to pregnant women, parents and children served by HANDS, the Health Access Nurturing and Development Services Program.

Medicaid Services Presumptive Eligibility Program for Pregnant Women is in place and will allow pregnant women to receive prenatal care through Medicaid for up to 90 days while their eligibility for full Medicaid benefits is determined.

In general, children and pregnant women in Kentucky are well supported through the KCHIP and Medicaid insurance systems. The service gap identified is for the adult males and non-pregnant females as well as for undocumented immigrants of all ages. And it is the latter group whose increasing numbers stretch the safety net system. Many local health departments are using Title V funding to provide prenatal services to this population.

KenPac - Implemented in 1985, the Kentucky Patient Access and Care (KenPAC) Program is a primary care case management program that increases access to primary and preventive health services and coordinates other Medicaid covered health care and related services for Medicaid members eligible to participate in the program. A pediatrician, internist, family doctor, general practitioner, OB/GYN, rural health clinic, primary care center or nurse practitioner acts as the primary care provider (PCP) for Medicaid members enrolled in KenPAC. Kentuckians who receive financial assistance through the Kentucky Transitional Assistance Program (K-TAP), [formerly Aid to Families with Dependent Children (AFDC)] and adults aged 19 and older who receive Supplemental Security Income (SSI), are enrolled in the KenPAC program. In 2001, the KenPAC program added a care coordination support function. The program is staffed entirely by experienced registered nurses that are located around the Commonwealth in areas with high Medicaid population densities. The KenPac care coordinators serve as a liaison between Medicaid and the KenPAC providers. Additionally, on a case-by-case basis, these nurses are available to assist with heath care service coordination for KenPAC recipients with unique health problems.

KCHIP: Eligibility is determined by the Dept for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid. KCHIP members enrolled are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

/2007/ The Fletcher administration has focused on modernizing the Medicaid program. Currently, the Kentucky Medicaid program covers more than 691,000 enrollees with an annual budget of $4.7 billion. Kentucky got the first Medicaid Waiver approved after the Federal Deficit Reduction Act. It will allow for pilot projects and more customized plans. including benefit management and technology through contracts for a Pharmacy Benefits Administrator (PBA) and a new Medicaid Management Information System (MMIS). Kentucky Health Choices will focus on improving the care for high-risk, high-cost patients, including long-term care and behavioral health patients, as well as individuals with special health care needs, through case and disease management. The program will also operate a 24/7 member services 800 number that will include access to a "nurse triage" medical advice call service to help members understand their illness and access

appropriate levels of care. Kentucky Health Choices will also coordinate a new provider credentialing process consistent with private sector practices, and peer review organization functions.Kentucky Health Choices' aim is to reduce costs and improve health outcomes by promoting healthy lifestyles, managing the care of high-utilizing patients and minimizing inappropriate care. //2007//

/2008/ Medicaid has recently announced a rate increase for physicians and dentists for the top utilized CPT codes. The increases will amount to $44M but hope to encourage more providers to participate and enhance preventative services, including after-hours care. The state has increased payment rates to dentists for children covered by Medicaid. By increasing payments by almost one-third, officials said, more dentists are expected to agree to treat medicaid children and pregnant women. Less than half of Kentucky's 2,265 licensed dentists accepted Medicaid prior to the rate increase. //2008//

An agreement is in place between the Dept for Public Health, Dept for Medicaid Services and Dept for Community Based Services. This agreement provides Medicaid reimbursement for targeted case management for Medicaid patients (including children in custody or at risk of being in state custody and adults in need of protective services) and for rehabilitative services for Medicaid-eligible children in custody or at risk of being in state custody.

The Dept for Public Health, Dept for Medicaid Services, Dept for Community Based Services and Dept for Mental Health/Mental Retardation Services also have an interagency agreement for provision of community-based mental health services to children who are in custody or under supervision of the state, or at risk of being in state custody; and have just been discharged from a psychiatric facility or at risk of institutionalization in a psychiatric facility.

Collaboration: Department for Mental Health and Mental Retardation (MHMR)

/2009/ In the Reorganization, effective June 16, 2008, The Department for Mental Health and Mental Retardation Services revised its name to the Department for Mental Health, Developmental Disabilities and Addiction Services. The new name reflects the focus of the programs and services provided by the department. //2009//

As part of the KIDS NOW Early Childhood Development Initiative, the Kentucky Division of Mental Health and Substance Abuse is working in partnership with the Dept for Public Health in a statewide effort aimed at increasing the health of all Kentucky babies by decreasing the use of alcohol, tobacco, and other drugs during pregnancy. Health departments screen pregnant women for alcohol, tobacco, and other drugs and women who fall into lower level risk groups can be referred for prevention services, while those in the high risk category can be referred for a fuller substance abuse assessment to the Comp Care system. As a result of this collaboration, thousands of pregnant women struggling with substance abuse issues in Kentucky are being reached. The Comp Care Centers working under the KIDS NOW Early Childhood Development Initiative provide substance abuse prevention and /or treatment services to pregnant women.

The Early Childhood Mental Health (ECMH) Program provides direct services to children identified through childcare as having possible mental health issues. Through this program there is a full time early childhood mental health consultant located in each regional mental health center to provide or refer these services. They also provide consultation to the childcare center and train childcare staff to problem solve classroom behavior problems and build resiliency in children. Another component of this program is to build capacity of mental health professionals working with children birth to five years of age by providing free trainings. This program has been presented as a "Model that Works" at the Association of Maternal and Child Health Programs (AMCHP) national meeting in 2006.

Additionally, a collaborative agreement is in place between these agencies to provide mental health services for childbirth to five with regional consultants both for consultation and direct

intervention primarily in the child care setting (Healthy Start in Childcare) and the Early Childhood Mental Health Program.

The MCH Branch has a collaborative agreement in place for Suicide Prevention Services and MCH staff serve on the Suicide Prevention Advisory Group. MHMR staff also serve as a member of the State Child Fatality Review Team.

The Substance Abuse Prevention team in MHMR, as part of the KIDS NOW Early Childhood Development Initiative, has been working with many of the MCH programs including the Prenatal program, Family Planning, Well Child and the Kentucky Birth Surveillance Registry. This collaboration is a statewide effort aimed at increasing the health of all babies by decreasing the use of alcohol, tobacco and other drugs during pregnancy. The program components will include outreach efforts aimed at better identifying pregnant and postpartum women in need of prevention or treatment, and collaborative efforts between substance abuse prevention and treatment services to provide a continuum of care.

In October 2004, Kentucky was awarded $11.5 million Strategic Prevention Framework State Incentive Grant (SPF-SIG) from the US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). The Strategic Prevention Framework is a process designed to increase the effectiveness of substance abuse prevention on the state and local level through collaborative interagency planning.

/2010/ New collaborations with Mental Health include the KY SEED Grant (see overview) and a workgroup on Substance-Exposed Infants. Also, Dr. Hacker, Commissioner of Health, is currently chairing the State InterAgency Coordinating Council for Children with Emotional Disabilities. This group will oversee the implementation of the SEED grant. //2010//

Collaboration: Kentucky Department of Education

KIDS NOW is the state's early childhood initiative passed by the legislature and is funded by 25% of the Phase I Master Tobacco Settlement dollars. The Early Childhood Development Authority Board, appointed by the Governor, guides the programs and ensures accountability. The Board includes parents and representatives from multiple departments and agencies including Public Health and the Commission for Children with Special Health Care Needs. Dr. Steve Davis, Deputy Commissioner of the Dept for Public Health and former Title V Director was one of the key architects of KIDS NOW and continues to be active on the Board.

The KIDS NOW Initiative is housed in the Department of Education, but works across department lines with Public Health, Education, the Commission for Children with Special Health Care Needs, Child Care, and Mental Health. The goal of the initiative and all partners is that "all children in Kentucky are healthy and safe, possess the foundation that will enable school and personal success, and live in strong families that are supported and strengthened within their communities." There is a strong evaluation component of the entire initiative and programs regularly report their progress to the board.

/2008/ The First Steps program has a Memorandum of Understanding with the Kentucky Dept of Education to facilitate transition from Part C (birth to three years) to Part B (three to twenty-one years). A full time staff works in communities to develop community-specific agreements for assuring transition steps and services for this population. First Steps also provides electronic notification to the school system to provide Child Find information to every school district for children in the First Steps system who are 30 months or older. This information is provided on a quarterly basis and includes basic contact information regarding the child and family. //2008//

Coordinated School Health: In 2003, Kentucky was selected as one of eighteen states to receive Centers for Disease Prevention and Control - Division of Adolescent School Health (CDC-DASH)

Coordinated School Health (CSH) Infrastructure grant. The Kentucky Dept of Education (KDE) and the Kentucky Dept for Public Health (KDPH) partner together to develop, implement and evaluate a coordinated school health program at the state level. The grant award is for $415,000 with $100,000 allocated to the Dept for Public Health to fund a full-time coordinator, travel and supplies. Additionally, 3 FTE positions have been established within the Dept for Education to support coordinated school health activities.

/2009/ Kentucky was one of twenty-two states and one Territory to receive a new five year Coordinated School Health grant award from the Centers for Disease Prevention and Control - Division of Adolescent School Health (CDC-DASH). This will allow a continuation of the infrastructure building and program development to promote the health of our youth so that our children become healthy, productive citizens. School Health issues was the focus of the Kentucky School Leader in Winter 2007-08. This magazine is a publication of the Kentucky Association of School Administrators. //2009//

Through this state infrastructure, schools and school districts, with assistance from local health departments and other partners, will create and/or strengthen local CSH Programs. CSH consists of an eight-component national model include health education, physical education, health services, nutrition services, counseling/psychological services/social services, health school environment, health promotion for staff and family/community involvement. This model is an organized set of policies, procedures, and activities designed to promote and sustain the health of students and staff. Many other programs within the Division are linked with this project, specifically through a CSH Interagency committee, which includes representatives from Tobacco, Substance Abuse Prevention, Asthma, HIV/AIDS, Well-Child, Abstinence Education, Family Planning, Diabetes, Nutrition, Obesity, Cardiovascular Health and Physical Activity.

/2008/ This group has developed a school-based resource guide book on physical activity, nutrition, tobacco and asthma (PANTA). The handbook was developed by the Kentucky Dept for Public Health and the Kentucky Dept of Education to provide assistance to schools in designing and planning policies and programs, encouraging environmental change, and promoting overall health of students, staff and the school community. This resource helps schools make the changes required by SB 172, our school nutrition bill. Resources are provided that encourage needs assessment [CDC's School Health Index], evidenced-based curriculum, best practices, model policies and answers to frequently asked questions. This guide is arranged in such a manner that it can be used as a whole document or by subject -- physical activity, nutrition, tobacco and asthma (PANTA).

Another key partner, Foundation for a Healthy Kentucky (http://www.healthyky.org/), has supported coordinated school-based projects through funding of school grants to expand, replicate or enhance Coordinated School Health Programs in Kentucky communities. Approximately $800,000 for school grants and evaluation were allocated.

/2010/ The KY DPH is collaborating with KDE on a workgroup to apply for stimulus funding to establish an Early Childhood Advisory Council. The grant is due in August 2010. //2010//

Collaboration - Kentucky Youth Development Coordinating Council

/2007/ The Commissioner for the Dept for Public Health is one of 20 designated members of the Kentucky Youth Development Coordinating Council which is given the duty of developing a strategic plan and common vision for KY's Youth serving agencies. //2007//

/2008/ The KY Youth Development Coordinating Council, established as a result of the 2006 legislation (SJR 184) supports adolescent health agencies and their efforts to promote positive youth development outcomes. The Commissioner of DPH is a participating member of the Council. Since the passage of SJR 184, the Council has met on a regular basis and is currently

meeting every other month. At these meetings the Council has made decisions that will lay the foundation for success and set the stage for significant progress over the next year. A first year goal is to conduct an inclusive process to develop a strategic plan for coordinating and improving youth services over the next three to five years. The Council decided to develop a three year strategic plan; the Council decided to assess current Youth Services Collaborative activities to connect and build on them; and the Council decided to enlist agency program resource people into the visioning and strategic planning process. Moreover, the Council formed four workgroups that will be composed of Council members and resource people: 1) Outcomes/Accountability; 2) Coordination; 3) Quality/Positive Youth Development; and 4) Opportunities to engage youth, families and communities. //2008//
/2009/ The Counci; has identified five outcomes it will work toward. They are: Youth Making Healthy Choices; Youth are Life Long Learners; Youth participate in Community Decision Making; Youth Develop socaila and emotional Competencies, Youth have know and skills to be productive in the 21st century. The Council held a retreat in June 2008 and engaged a national expert from the Forum for Youth Development to establish performance indicators for the above five measures. //2009//

Collaboration: Tertiary Centers

The Division of Adult and Child Health Improvement has contracts with both the University of Louisville and the University of Kentucky for tertiary activities in the areas of genetic services, neonatal care, metabolic services, sickle cell and developmental services. The tertiary centers also provide invaluable consultation and educational offerings to ACHI and hundreds of providers across the state.

-University of Louisville

Community Development Evaluation Services: Community Development Evaluation Services are provided to the Western half of Kentucky through the U of L Child Evaluation Center. They provide 325 multi-disciplinary tertiary evaluations and 260 single-discipline evaluations to children birth to sixteen to determine complex developmental disorders, program eligibility and service recommendations as well as support and educational services to families and health providers. Evaluations are done both at the University's Child Evaluation Center and through a series of traveling clinics across the western half of the state.

High Risk Infant Follow-up Project: The Neonatal Follow-Up Clinic provides developmental screening assessments for high-risk and premature infants for the Western half of Kentucky. The staff provides center based multi-disciplinary neuro-developmental screening to interpret diagnoses to families; identify intervention needs, and initiate specialty referrals. These evaluations are done at both the University's Neonatal Clinic in Louisville and at regional neuro-developmental screening clinics housed in western Kentucky hospitals. In addition, the staff provides technical assistance and education to Pediatricians and other health care professionals on how to manage the needs of the premature, high-risk infant they are serving in their local communities. ***/2010/ The University will also assist in the development of a Kentucky Perinatal Quality Collaborative. //2010//***

Other Contracts Impacting Maternal and Child Health include metabolic screening and case management for children with identified conditions; genetics referral and outreach, maternal mortality, nutrition education for providers of high-risk women; physician and public health nurse continuing education and oral health survey implementation and data analysis.

/2008/ The University of Louisville, College of Medicine will assist DPH to develop and administer a statewide Fetal and Infant Mortality Review (FIMR). //2008//

-University of Kentucky

KY Injury Prevention Research Center works with the DPH Child Fatality Review and Injury Prevention program to facilitate, develop policy, gather and analyze data to identify trends, patterns and risks, provide technical assistance and training, and to review, make proposals and implement strategies to improve the child fatality review and injury prevention system, with an emphasis on coordinating partnership prevention efforts. The Injury Prevention center also cooperates with CDC on the Violent Death Reporting System and the SUIDI project.

Infant Intensive Care Project: The Infant Care Project provides multi-disciplinary developmental assessments to acutely ill children to interpret findings to families; identify intervention needs and to initiate specialty referrals. These services are provided to children admitted to the NICU. ***/2010/ The University will also assist in the development of a Kentucky Perinatal Quality Collaborative. //2010//***

The DPH also has an active collaboration with the state-wide network of county extension agents through the UK Cooperative Extension Agency. Community topics include nutrition, physical activity, smoking cessation and general health promotion.

/2008/ The University of Kentucky will develop and administer a MCH Institute in the College of Public Health. //2008//

Collaboration - CYSHCN and Partners

The Commission coordinates a MOA with the Dept for Medicaid Services that enables the Commission to provide therapeutic remedial services for applicable Medicaid eligible children enrolled for Title V/CSHCN services This agreement references the applicable federal and state statutes or regulations and assure that services are provided in accordance with the Title XIX State Plan and EPSDT special services as required by OBRA 89.
Besides key partnerships with ACHI and Medicaid, the Commission for Children with Special Health Care Needs has historically maintained and built new partnerships to enhance the system of care for CYSHCN. In the past year the Commission has worked with the Cabinet for Families and Children to identify Title V/CSHCN enrollees who are residing in foster care and to share program information that will assure coordination of services for children in foster care.

The Commission maintains a strong relationship with the KY Dept of Education, with the Executive Director serving on the State Advisory Panel for Exceptional Students. A MOA between CCSHCN and KDE calls for exploring avenues to link transition related data sets to measure and monitor student progress. The state agency for protection & advocacy, developmental disabilities council, and the university center for excellence in addition to the departments for community based services, vocational rehabilitation, and employment services are partnering with the Commission in the Family Support 360 Planning Grant. The Commission serves on the Dept for Mental Health's Co-Occurring Disorders Workgroup, which is studying the need for appropriate behavioral supports for the growing number of CYSHCN presenting with dual diagnosis. A representative of the Commission serves on the state early intervention Interagency Coordinating Council. The Commission also partners extensively with the two state medical schools and their teaching hospitals for specialty care for CYSHCN enrolled in the Title V medical services program.

/2010/ Developmental Disability Council

The mission of the Kentucky Council on Developmental Disabilities is to create change through visionary leadership and advocacy so that people have choices and control over their own lives. Note: KCDD does not provide direct care services

The Kentucky Council on Developmental Disabilities (KCDD) was authorized by Executive Order of the Governor, in accordance with Public Law 106-402, the Developmental Disabilities Assistance and Bill of Rights Act.

The KCDD is comprised of 26 members, 16 of whom are appointed by the governor. The makeup of the KCDD is unique in that 60 percent of its members are individuals with developmental disabilities or are parents or guardians of individuals with disabilities. The remaining members are representatives of each major state agency that serves people with developmental disabilities in Kentucky.

KCDD membership also includes representatives from the state's University Center for Excellence in Developmental Disabilities and the state's Protection and Advocacy system.

History of KCDD
In 2001, the council began operating under a new five-year plan based on nine areas of emphasis outlined by the Developmental Disabilities Assistance Act (DDA) Public Law 106-402 of Oct. 30, 2000. These areas of emphasis are used to fulfill the purpose and intent of the DDA and the mission and vision of the council. Beginning in 2002, the council began operating under a new name, the Kentucky Council on Developmental Disabilities, to better reflect its role in the commonwealth. //2010//

An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

The Department for Public Health, Division of Maternal and Child Health is responsible for promoting normal growth and development and safeguarding the health of Kentuckians of all ages, with emphasis on pregnant women, infants, and children. Its activities include public health education, nutrition, injury prevention, coordinated school health, perinatal care, early childhood intervention and promotion, well child care, oral health and selected primary and preventative care activities. Its activities span the spectrum of population based and personal preventive health services delivered through a wide range of health care providers and related groups to promote good physical and oral health for all age groups.

The state MCH programs work closely with Medicaid and other agencies to develop strategies to enhance Health Systems Capacity as measured on these indicators. Kentucky Medicaid has been very supportive of providing care for MCH populations. The Medical Director for Medicaid, Dr. Tom Badgett, is a pediatrician. One year ago, Medicaid announced a $44 million package to increase provider reimbursement for the most common CPT codes, which will encourage more pediatricians and obstetricians to participate. The package also provides incentives like enhanced reimbursement for after hour visits in the office/ medical home. In addition, the package has shifted some of the dental reimbursement from adult care to enhance the reimbursement for dental services to children. Very few dentists in the state are willing to see Medicaid children, so we are hoping this increased reimbursement rate will improve that access as well.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	60.6	56.2	47.8	45.8	45.8
Numerator	1652	1541	1315	1276	1276
Denominator	272789	274199	274947	278330	278330
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 KY inpatient hospital discharge data will not be available until late summer of 2009; therefore, the 2008 numbers actually reflect 2007 data.

Notes - 2007
Data includes a primary, secondary or tertiary diagnosis code of 493.0-493.9.

Narrative:
PANTA School Resource Guide -- Recognizing Kentucky has a large number of children with asthma; asthma was added to a resource guide for schools. The guide was developed through a collaborative effort of DPH Tobacco, Obesity-Prevention, and Coordinated School health programs, along with the Kentucky Department of Education.
The guide provides assessment tools, evidence-based interventions, and sample policies for Physical Activity, Nutrition, Tobacco, and Asthma [PANTA]. The guide may be downloaded at http://chfs.ky.gov/dph/ach/cd/pantaguide.htm

School-Based Health
Local Health Departments provide a large number of school-based health services - it is one of the largest volume services for health departments overall. In addition, 16 sites have school-based health centers staffed by a health care provider (pediatrician and/or ARNP). These centers are supported by local funding. One center in Lexington has instituted asthma screenings by the pediatric pulmonologist from UK. In the last legislative budget, additional monies were earmarked to expand school based health services. This was accomplished by funding local health departments to partner with school based health centers to enhance services.

/2009/ DPH is partnering with the Kentucky Department of Education, the Kentucky School Boards Association, and the Kentucky Association of School Administrators to develop a statewide asthma management plan for Kentucky schools. The plan would include collecting data and providing information to key partners and stakeholders; educating school administrators, faculty, staff, and students on appropriate asthma management and emergency response; and communicating among schools, students with asthma, their parents and their physicians.

Kentucky has designated approximately $150,000 of Preventive Health and Health Services Block Grant funds for a full-time asthma program manager and money to begin building an asthma program at DPH. This would include providing resources and information to local health departments that are interested in using discretionary funds to begin developing asthma programs, coalitions, and partnerships at the local level.

DPH has initiated an Asthma pilot program in Montgomery County that includes education, collaboration with local physicians, partnering with school nurses on asthma management and building of a community coalition. The Montgomery County Asthma Pilot Program also works to educate the Spanish speaking community.

DPH also works with the American Lung Association of Kentucky to promote their Asthma Educator Institute to local health department employees who are interested in becoming Certified Asthma Educators. //2009//

Medicaid Pediatric Asthma Initiative
The Department of Medicaid Services (DMS), Division of Medical Management and Quality Assurance (MMQA) implemented this disease management initiative for pediatric asthma.This

initiative has targeted the age ranges of five (5) to seventeen (17) years of age. The counties selected to participate in the pilot include Perry, Pike and Powell. These counties are all located in Eastern Kentucky. However, the vendor for the disease management programs changed, and the results of this pilot were not evaluated.

DMS has adopted specific guidelines from the National Heart, Lung, and Blood Institute (NHLBI). A chart abstraction was performed that included demographics, history, medications, utilization of services and education. Members and providers are encouraged to fill out an Asthma Action Plan for each child. This is followed by educational mailings and follow-up data is collected by survey and Medicaid utilization data. A member 1-888# and staff are available for comments, to assist members and health providers and to answer questions as needed.

Kentucky Pediatric Society (KY AAP) has members who are piloting model programs for asthma management in their offices as a quality improvement activity.

/2010/ In March, 2009, the Kentucky Respiratory Disease Program completed the Kentucky Asthma Surveillance Report, 2009 and the 2009 Kentucky State Plan for Addressing Asthma. Both documents are being distributed to key partners and have been made available on the programs web-site. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	78.6	77.0	78.8	78.8	72.0
Numerator	16677	16624	17626	17626	51098
Denominator	21230	21580	22354	22354	70991
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Numerator and denominator calculations have changed for this indicator. For numerator information, the HEDIS technical specifications for well child visits as accepted for HEDIS measures was used to determine procedure and diagnosis codes used for periodic screen. The HEDIS measures were used since they are a recognized national standard and would provide consistency in reporting over time.

Preventive codes for periodic screen based on the HEDIS specifications included the following codes: 99381,99382,99391,99392,99432,V202,V703,V705,V706,V708, and V709

For denominator information, the age calculation changed for determining eligibility. Since age is not static, a child could have been born in the previous year but still be eligible for services and under one year of age in the following year; therefore, calculations were adjusted to reflect this and enrollment numbers have changed.

Notes - 2006

Data for this indicator is derived from the CMS annual 416 EPSDT participation report for year 2006.

Narrative:
The Kentucky Department for Public Health is working with the Department of Medicaid Services to increase screenings with EPSDT outreach. The Department for Public Health allocates money to all local health departments for EPSDT outreach. The health departments work a list of eligibile children which is provided by Medicaid. This program has created a full time position within the Maternal and Child Health branch, which will allow us to work more closely with local health departments to develop and/or expand their EPSDT outreach program.

The Department for Medicaid services administers statewide EPSDT and KCHIP Outreach through contracts established with the Department for Public Health. During FY 08, the Department for Public Health reinforced EPSDT Outreach through development of outreach goals and objectives, workshops and training for health department providers, and improvement of reports and feedback used by health departments for implementation of verbal notification of eligible Medicaid children. To assure a resource for information about KCHIP enrollment and referral to health care providers, the Department for Public Health allocates funds to two health departments to administer the statewide KCHIP outreach hotline, providing touchtone dialing and translation services.

Medicaid is also encouraging EPSDT screenings to include Lead poisoning. The Medical Director for Medicaid, Dr. Tom Badgett, is a pediatrician and is working on strategies to get more pediatricians involved and more consistent with EPSDT.

/2010/ The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one periodic screen declined from 78.6% in FY 2004 to 71.9% in FY 2008.

In FY 2008, the number of Medicaid enrollees, age less than one year during the reporting year, who received at least one periodic screen increased from 16,677 (78.6%) in FY 04 to 51,092 (71.9%) in FY 08.

The Department for Medicaid services administers statewide EPSDT Outreach through a contract established with the Kentucky Department for Public Health (KDPH). During FY 09, the Department for Public Health improved EPSDT Outreach through monitoring outreach goals and objectives, by providing local health departments with training and technical assistance as well feedback about program performance, and by joining the Department for Medicaid services, health departments in 120 counties, statewide community agencies and providers on November 1, 2008 to promote outreach to the 67,000 children estimated to be uninsured in Kentucky and to enroll more than 35,000 additional children in KCHIP by June 30, 2010. To facilitate enrollment, DPH and DMS partnered to present 2 statewide videoconferences to health departments and other community agencies. These videoconferences were made available to providers on line through TRAIN. EPSDT outreach further expanded verbal notification activities to enroll more uninsured and underinsured children in the Medicaid program and KCHIP programs.

Additionally, the Department for Public Health allocates funds to two health departments to administer the statewide KCHIP outreach hotline, providing information about KCHIP enrollment, touchtone dialing and translation services, and encourages statewide local health department outreach efforts to increase KCHIP enrollment.

Through 2002-2005, a grant from the Robert Wood Johnson Foundation supported the Kentucky Covering Kids & Families Coalition outreach initiative to focus on coordinated statewide outreach, policy development, application assistance and facilitation of interviews for Medicaid and SCHIP eligibility determination. Although the Kentucky

Covering Kids & Families Coalition currently remains unfunded, the organization met with state agency and private health care partners during fiscal year 2009 to advocate support for the reauthorization of KCHIP, consider funding measures and resources for outreach and services and develop strategies to implement the Kentucky Governor's KCHIP enrollment initiative.

Additional efforts were initiated in FY 09 to assure coverage for eligible children, including use of Title V funds to cover expenditures for services provided by Kentucky health departments for children who are not covered or eligible for Medicaid:

1) In Jefferson County and 15 Kentucky counties, Passport Health Plan assures services for children who are eligible for Medicaid or KCHIP coverage. During FY 09, Passport Health Plan partnered with Jefferson Louisville Metro Health Department to increase Medicaid and KCHIP enrollment among uninsured and underinsured children in Jefferson County.

2) In FY 09, Citizens of Louisville Organized and United Together (CLOUT), Passport Health Plan and other Jefferson County advocates of coverage for uninsured children established a coalition and met as often as monthly to consider, develop and reinforce initiatives to increase awareness of KCHIP in the community and enroll eligible children in KCHIP. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	77.9	81.0	84.1	79.9	61.4
Numerator	342	372	371	528	308
Denominator	439	459	441	661	502
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Numerator and denominator calculations have changed for this indicator. For numerator information, the HEDIS technical specifications for well child visits as accepted for HEDIS measures was used to determine procedure and diagnosis codes used for periodic screen. The HEDIS measures were used since they are a recognized national standard and would provide consistency in reporting over time.

Preventive codes for periodic screen based on the HEDIS specifications included the following codes: 99381,99382,99391,99392,99432,V202,V703,V705,V706,V708, and V709

For denominator information, the age calculation changed for determining eligibility. Since age is not static, a child could have been born in the previous year but still be eligible for services and under one year of age in the following year; therefore, calculations were adjusted to reflect this and enrollment numbers have changed.

Narrative:
/2010/Medicaid has been collaborating with the Department for Public Health to encourage EPSDT screening. Outreach thru the local health departments includes outreach to children eligible for KCHIP.

The Department for Medicaid services administers statewide EPSDT and KCHIP Outreach through contracts established with the Department for Public Health. During FY 08, the Department for Public Health reinforced EPSDT Outreach through development of outreach goals and objectives, workshops and training for health department providers, and improvement of reports and feedback used by health departments for implementation of verbal notification of eligible Medicaid children. To assure a resource for information about KCHIP enrollment and referral to health care providers, the Department for Public Health allocates funds to two health departments to administer the statewide KCHIP outreach hotline, providing touchtone dialing and translation services.

To assure a resource for information about KCHIP enrollment and referral to health care providers, the Department for Public Health allocates funds to two health departments to administer the statewide KCHIP outreach hotline, providing touchtone dialing and translation services. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	75.6	70.5	75.4	73.4	75.5
Numerator	42141	37800	42150	42704	41240
Denominator	55775	53647	55893	58164	54599
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is preliminary.

Notes - 2007
2007 data is preliminary.

Narrative:
Kentucky's women are receiving adequate prenatal care as based on calculations using the Kotelchuck index. In 2000, 80.6% of women of childbearing age in Kentucky received adequate prenatal care and in 2001, this number rose slightly to 80.8%. Data for this measure continues to increase steadily with 82% of women receiving adequate prenatal care, based upon the Kotelchuck Index in 2003.

Following the Kentucky's switch to the new birth certificate in 2004, this indicator was calculated differently than in the past and therefore numbers are not comparable. Like other states who switched, we struggled with how to best calculate this indicator based on the new data source. We have participated in the discussions of this with our Region IV states, and recently received the formula developed by Dr. Bill Sappenfield and now distributed by NCHS. This data is recalculated by the new formula and may be a more accurate representation of this issue. We are currently examining our data by risk factors and geography to develop strategies to address.

/2010/ Kentucky currently uses the method established by the NCHS for calculating entry into prenatal care. Due to this new method change, we have seen a decline in the percent of women with adequate and adequate plus prenatal care. Detailed multi-variate logistic regression analysis has been conducted to assess if the decline is real. Results from the analysis comparing births pior to and after the new birth certificate indicate the decline is due to the new method of calculation and not a reflection of decline in the receipt of services, since significant demographic variables remained the same for both groups of women that received adequate and adequate plus prenatal care. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	85.4	89.2	97.8	91.5	94.4
Numerator	356053	361554	470710	436253	461330
Denominator	416878	405239	481324	477020	488685
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Medicaid claims can be paid for up to one full year from the date of service so the data is not complete and still considered to be preliminary.

Narrative:
Kentucky Medicaid covers nearly half of all births in the Commonwealth per year and provides health coverage to one out of every three children.

The Medicaid waiver, the first approved after the Deficit Reduction Act of 2005, will eliminate the one-size fits all approach to Medicaid, improve the health status of Kentuckians enrolled in the program and ensure that people receive the right care, in the right setting, at the right time.

The Medicaid Waiver will consist of 4 plans and placement will be determined by level of care:

1. Global Choices will cover the general Medicaid population program including foster children and medically fragile children.
2. Family Choices will cover most children including the SCHIP children.
3. Optimum Choices covers individuals with mental retardation and developmental disabilities in need of long term care.
4. Comprehensive Choices covers individuals who are elderly and in need of a nursing facility

level of care and also individuals with acquired brain injuries.

Members will be encouraged to participate in prevention and disease management programs. Disease management programs will be developed throughout the state to assist those with chronic illnesses such as pulmonary disease, cardiovascular disease, pediatric obesity, asthma and diabetes. Get Healthy Benefits will be established to provide incentives to Medicaid members for healthy behaviors.

Children less than 19 years of age will have no MD or preventive office visit co-pays.
Co-pays for children will be on ER Visits and RX only w/ limits of 4 RX @ month and 8 ER visits @ year
Maximum out of pocket per individual per service is $225.
Effective date was May 1, 2006.

The name for the EPSDT Program would be changed to the Children's Health Preventive Program.

/2010/ For CY 2008 461,330 Kentucky children and young adults through age 21 received at least one service resulting in a Medicaid claim.

The number of Medicaid-enrolled children receiving at least one service increased from 356,053 (85.4%) in 2004 to 461,330 (94.4%) in 2008.

In order to meet the demands for the increased number of children's preventative visits by the local health departments, in part due to the rise in school health services, the DPH Well Child Certification training process has changed. The web-based curriculum on Bright Future and EPSDT for health care providers is presented as 23 web-based trainings. The web-based training provides a pre and post-test with printable handouts attached with each web cast. After successful completion of the 23 web casts and passing the post-test with a minimum of 88% the Registered Nurse is then able to contact the University of Louisville Children and Youth Project Clinic to schedule for the required three day practicum. The nurse has to complete 25 required physicals with a preceptor (a physician, certified ARNP, Pediatric Nurse Practitioner or another certified Well Child Nurse) within a six month time frame. The physical examinations require five from each of the following age groups, infant, toddler, preschool age child, school age child, and adolescent. Upon completion of these two requirements the nurse then receives a certification to provide well child/EPSDT services. The nurse is required to attend one update on well child assessment every three years

In addition to on-site clinic services, local health departments collaborate with local school boards for provisions of child and adolescent preventive health services in a school setting, promoting improved access to health information and preventive health services for school age children. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	35.1	35.1	49.4	50.6	43.6
Numerator	31127	31127	35206	38417	55116
Denominator	88766	88766	71302	75954	126302
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Numerator and denominator calculations have changed for this indicator. For numerator information, Passport, the managed care portion of Medicaid that includes 16 counties in KY was included in 2008 when it had not been included previously.

For denominator information, the age calculation changed for determining eligibility. Since age is not static, a child could have been born in the previous year but still be eligible for services and under one year of age in the following year; therefore, calculations were adjusted to reflect this and enrollment numbers have changed.

Narrative:

The Kentucky Oral Health Program continues to work to improve the access for care for children with Medicaid and KCHIP in the following ways:

• The Kentucky General Assembly increased Medicaid reimbursement rates for dental services to Kentucky children by approximately 30 per cent.
• The Kentucky Dental Association continued to be proactive in their promotion of Kentucky dentists serving children eligible for Medicaid and KCHIP. This association was also the lead champion of HB 186, which requires a dental examination or assessment for all incoming five and six year old students into the public school system. They will become a major force in the implementation of this law in upcoming years and have tasked their members to assure services in their local communities.
Strong partnerships have been developed between the Kentucky Oral Health Program, local health departments and dentists, to promote dental care for Medicaid and KCHIP eligible children, particularly the very young patient, ages 1-5 years.
• Kids Smiles Fluoride Varnish trainings were provided at 33 regional training sites to approximately 1600 health department nurses and other providers since 2003. For 2008, 39,875 Pre-packaged fluoride varnish kits were provided to local health departments and Commission clinics. Fluoride varnish is now part of the Medicaid Preventive Health package.
• The Kentucky Children's Oral Health Surveillance System continued with pilot screenings held at selected Kentucky schools, which enabled project planners to calibrate data collection methods in preparation for the beginning of on-going surveillance activities in fall of 2009. DPH and UK are coordinating efforts to continue surveillance in 09 with further saturation of there activities as the University expands its coverage in rural Kentucky.
• Kentucky's sealant program funded sealant activities in fifteen local health departments. In collaboration with local dental hygienists and dentists as well as community schools, local health departments were provided with funding to purchase portable dental exam equipment. These partners worked together to provide screenings and sealants on Kentucky 2nd, 3rd and 6th graders throughout the Commonwealth. Targeted schools have an increased number of Medicaid eligible children. Parents were informed on the program through informed consent signature forms College of Public Health.
• With funding received from the Oral Health Collaboration Systems Grant (MCHB/HRSA) for a state-wide Oral Health Strategic Planning process, the Kentucky Oral Health Strategic Plan was published and distributed in the spring of 2006. Numerous areas of oral health needs for Medicaid and KCHIP eligible children and suggested initiatives for reducing these needs were identified in the strategic plan. It continues to be a guiding document for the activities and policies of the Oral Health Program.
• The HANDS Home Visitation Program stressed the importance of oral health to overall health for Kentucky's children and their families during HANDS services to over 10,967 Kentucky

families and completion of 137,230 (over 11,000 a month) home visits. Through a separately defined part of the home visit, the Case Management Nurse Professional is providing fluoride varnish application to all eligible children in the HANDS client's home.
?KOHP and Health Care Access Branch staff continues to collaborate regarding the application for Dental Health Professional Shortage Areas in Kentucky. Currently there are 17 Dental Health Profession Shortage Areas in Kentucky, 12 of which are located in the Appalachia.
?Eighty-five Second Year students at the Pikeville College of Osteopathic Medicine completed 4 days of Oral Health training.
?Kentucky's Oral Health Program is an applicant for a HRSA grant that will train general dentists in effective pediatric dental management with emphasis on the young Medicaid population. This will greatly expand the capacity of the dental delivery system as more generalists become competent in treating this population. Because of its importance to the general health status of Medicaid children, other funding will be sought out if Kentucky is not successful in being awarded this grant.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.7	9.5	9.8	7.3	7.1
Numerator	1699	2176	2255	1797	1795
Denominator	22161	22902	22902	24709	25335
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source for numerator is the CCSHCN database. Data source for denominator is the Social Security Administration.

Narrative:
/2010/ Though the Commision no longer offers separate programming for children receiving SSI benefits we will continue to document services to SSI eligible children and youth who qualify for services in the CSHCN medical program. The Commission will also continue to partner with the Social Security Administration and Disability Determination Services to provide outreach and referral information to families who apply for SSI disability benefits for children or youth under age 16. Families of young SSI recipients and youth under age 16 who receive SSI benefits may contact the Commission at 1-800-232-1160 or by email from the agency website: CCSHCNWebPage@ky.gov, for assistance in locating resources to meet medical or rehabiltative needs that are not covered under Title XIX-Medicaid. //2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			**MEDICAID**	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	10.5	7.4	8.8

Narrative:
/2010/ Comparison of health system capacity indicators for Medicaid, non-Medicaid, and for all MCH populations in the State. The comparison data is obtained from payer source information on KY Birth Certificates. Data Linkage between Vital Statistics and Medicaid for this Health System Capacity Indicator has not been achieved.

Since 2003-2005, the KY Low Birth Weight (LBW) rate rose slightly from 8.5% to 9.1% but may have leveled off in 2006 and 2007 to 9.1%. In 2008, the KY LBW shows a decline from 9.1% to 8.8%. Data shows that the LBW rates are much higher in Medicaid population (10.5%) as compared to non-Medicaid population (7.4%). Most of the programs addressing poor birth outcomes are targeted towards Medicaid population. Some of our strategies for attacking this problem include:

HANDS home visiting program -- 2008 evaluation findings showed that participants younger than 20 and between 20-24 years had lower rate of low birth weight babies as compared to non-participants in the same age groups(2002-2005). The program's efforts to decrease LBW births include: support and follow-up for early entry into prenatal care, support for a medical home, provide information on smoking, secondhand smoke and pregnancy, nurse and social worker visits that focus on signs of premature labor, depression screening, and prenatal curriculum that focuses on nutrition, stages of fetal growth, exercise, expectations of infant, labor and delivery.

GIFTS (Giving Infants and Families Tobacco Free Starts) is a prenatal smoking cessation program that offers individualized counseling to pregnant women who smoke, have recently quit smoking in the previous 3 months, or are exposed to secondhand smoke. Currently, only women who receive services at the local health department within a nine county region in KY are eligible, regardless of payor source. Education and counseling is ultimately targeted toward smoking cessation, but a reduction in smoking is also encouraged. These women are educated on the both maternal and neonatal complications of prenatal smoking and exposure to secondhand smoke, such as low birth weight and prematurity. From February 11, 2008 to February 28, 2009, 540 women have enrolled in GIFTS and 23.1% of the enrolled women have quit smoking.

Medicaid currently has a disease management program for pregnant women that have diabetes.

Centering Pregnancy -- A research team at the University of Kentucky established partnerships with the Center for Women's Health (CWH) at Trover Health Systems to address community needs of poor birth outcomes. Their program is called Centering Pregnancy Smiles (CPS) and has an oral health component. During 2006 and 2007, 447 women were enrolled in prenatal care delivery program and of this number, 379 women gave birth. The singleton LBW rate for mothers who participated in the program was 5.3% for all births in 2006 and 2007. A second Centering Pregnancy program is at the Bluegrass High Risk Obstetrics Clinic at the University of Kentucky, which serves a large number of Hispanic mothers. The program began in 2006 and 172 women have participated in the program from 2006-2008. The Low Birth Weight rate for these participants was 3.5%. Majority of the mothers who participated in this program were low-risk Hispanic women.

Healthy Start Program - In FY 2007-08 the LBW rate for healthy start participants was 9% and the VLBW rate was 1.5%. This data has been obtained from the Healthy Start database and has not

been verified using vital records. In 2009, the Healthy Start Program will to focus recruitment efforts on African American women and other women who are at high risk for poor pregnancy outcomes.

Preconception Care - The Kentucky Department for Public Health promotes preconception healthcare for women in their childbearing years, ages 15-44, as a required service in local health departments. This includes counseling on folic acid and providing a multivitamin with 400 mcg of folic acid free, or at a substantially reduced cost, through the KIDS NOW Initiative funding from the master tobacco settlement agreement. The Family Planning Public Health Practice Reference (PHPR) requires all family planning clients receive preconception counseling and folic acid supplementation. Staff are developing a more comprehensive preconception program and are considering applying for a Title X Waiver. //2010/

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	7.1	4.1	5.8

Narrative:

/2010/ The death of any infant or child is a tragedy and a traumatic event for a family and community. Infant mortality, the death of a child any time during the first year of life, is also an important health measure. It not only reflects the current health status of a population but also provides an indication of maternal health, quality of care, access to care, socioeconomic conditions and public health interventions. In the last twenty years, the infant mortality rate in Kentucky has fallen dramatically and run very close to the national average. From 2003 to 2005, the infant mortality rate in Kentucky remained constant at 6.8 per 1,000 live births. From 2005 to 2006, this rate increased to 7.4 per 1,000 live births which was the first increase in Kentucky since 2001. Preliminary data from 2007 (6.4 per 1,000 live births) and 2008 (5.8 per 1,000 live births) suggest that this increase may be a natural fluctuation in the data. In 2006, the last year of complete data, the three leading causes of infant mortality in Kentucky were prematurity, congenital anomalies and sudden unexpected infant deaths (SUID).

Kentucky has investigated the increase in infant mortality in 2006. A comparison of infant deaths by age at time of death (<7 days, 7-27 6/7 days, 28 days -364 days), cause of death, and birth weight did not identify any potential reason for the increase. An analysis comparing birth rates to infant mortality rates using eight birth weight categories (<500 grams, 500-599 grams, 600-749 grams, 750-999 grams, 1000-1249 grams, 1250-1499 grams, 1500-2499 grams and =2500 grams) revealed that the infant mortality rate increased in 2006 while the birth rate decreased in the two weight categories of 1000-1249 grams and 1250-1499 grams. Further analysis is now being conducted on these birth weight categories.

The issue of infant mortality is addressed by the Child Fatality Review program which was legislatively established in 1996 for the purpose of learning from child deaths in order to reduce the number of child fatalities. This legislation called for cooperation and communication among agencies along with the collection and analysis of data for trends, patterns and risk factors as well as evaluation of the effectiveness of prevention and intervention strategies.

The Kentucky Child Fatality Review Program follows the guidelines of the National Center

for Child Death Review. The Kentucky State Child Death Review Team meets every other month and is organized to discuss and analyze data from a statewide perspective. The state review team is a multidisciplinary body from the community, and deaths that need further evaluation are brought before the state team for review. The state team provides technical assistance to existing local teams and facilitates the development of teams in counties that do not participate in the process. Additionally, the state team produces an annual report as required by legislation. Information on infant mortality in Kentucky can be found in the Kentucky Child Review Fatality Review System Annual Report which is submitted each year in November.
Kentucky is also in the process of establishing two fetal infant mortality review projects in Kentucky. The review teams in these areas will provide more accurate data on fetal and infant deaths along with the identification of risk factors and potential prevention strategies. In addition, system barriers that may influence infant mortality may be identified and addressed by the community team members. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	60.8	78.2	72

Narrative:
The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. This could be a possible reason for the decline observed.

/2010/ Prenatal Care data based on revised certificate show that the rates of prenatal care utilization have declined than data from the unrevised certificate. Most of the difference can be attributed to changes in reporting and not to changes in prenatal care utilization. Current data shows that in KY the rate of prenatal care utilization is 1.3 times less in Medicaid population as compared to non-Medicaid population. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	68.7	81.8	75.5

Narrative:
The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. This could be a possible reason for the decline observed.

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and for all MCH populations in the State. The comparison data is obtained from payor source information on the Birth Cetificates. Data Linkage between Vital Statistics and Medicaid for this Health System Capacity Indicator has not been achieved.

/2010/ The changes made in the calculation of the indicator for prenatal care utilization are reflected in this indicator also for calculating the adequacy of care since both the indicators use same variables for calculation. The adequacy of prenatal care is higher in non-Medicaid population (82%) as compared with Medicaid population (69%). //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Narrative:
Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	200

Narrative:
Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	185

Narrative:
Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
Currently, the Division of MCH has the ability to access many types of maternal and child health data through the work of Epidemiologist, Tracey Jewell, MPH. Ms. Jewell works analyzing vital statistics data, service data (through the Patient Services Report System -- local health department service/payment data), Kentucky Birth Surveillance Registry (KBSR) data and Family Planning Annual Report (FPAR) data and other information as needed. Ms. Jewell has direct access to Vital Statistics Data and can obtain data from Hospital Discharge Database, WIC and other databases.

We are beginning to link Vital Statistics live birth certificates on an annual basis to death certificates. Ms. Jewell has direct access to all electronic files regarding vital events for Kentucky. The birth and death records are linked through the process of running a SAS program that links death certificates to birth certificates based on pre-defined variables and criteria. We still need to refine this process in order to achieve data linkage >97%. This process creates a temporary SAS dataset from which detailed analysis can be performed on linked records.

A major IT focus in Kentucky is the development of KBirth by which birthing hospitals would utilize one system for electronic reporting of live birth certificate information as well as newborn blood spot screening data and newborn hearing screening data. The project is operational at all birthing hospitals in the state. Future efforts of the SSDI grant will focus on utilizing the referral system developed for KBSR to facilitate the referral of individuals identified with hearing loss through the newborn hearing screening program to First Steps for early intervention services.

/2010/ Data Linkage Activities:

The Division of Maternal and Child Health (MCH) has been working closely with the Office of Vital Statistics from the Division of Epidemiology and Health Planning to create and sustain a consistent approach to linking infant death certificates to their corresponding certificate of live birth thereby creating a permanent linked data set of infant death records

to birth certificates. This task has been undertaken by the data analyst from the Office of Vital Statistics, the senior Epidemiologist from the Division of Epidemiology and Health Planning, an Epidemiologist with the MCH branch, and the senior MCH Epidemiologist. This workgroup met several times to formalize a plan and develop a linkage algorithm for testing to be utilized in creating the official linked file for Kentucky.

An initial SAS program was developed by the workgroup and tested by all four group members. The program code was modified as appropriate to ensure all possible links were captured. The algorithm links the certificates in a two step process first linking on the birth certificate number followed by the infant's first and last name, gender, and date of birth. The linked data is reviewed for accuracy and those records that did not link are being matched through a hand-match process. The Office of Vital Statistics is also creating a linked file based on the paper certificates that are received in the office. Once the death certificate of an infant is received vital statistics staff verifies the child's corresponding birth certificate number and write it on the death certificate. These records are then entered into an electronic database which is updated on a monthly basis.

The electronic database created by Vital Statistics is being utilized to cross-check the data linkage algorithm developed by the workgroup. Linked data from both systems are being compared to determine if all possible links are being captured by both methods. Once a thorough review of both methods has occurred, the workgroup will meet to discuss the results and make any necessary adjustments to either system as needed. The SAS linkage algorithm will continue to be used to monitor and validate the linked file being created in vital statistics. The official linked file of infant deaths to birth certificates will be housed in the Office of Vital Statistics and those individuals wishing to access the file will be able to through a formal request and will receive de-identified data. Members of the workgroup will have access to both systems and will continue to run the SAS algorithm on a monthly basis as a cross-check for both systems.

Calendar year 2008 linkage activities:
The Division of Maternal and Child Health continues to work with the Division of Epidemiology and Health Planning, Office of Vital Statistics to maintain a consistent and accurate approach to linking infant deaths to birth records. The workgroup will be meeting with Vital Statistics in the near future to compare the linked file with the linked file created by the National Center for Health Statistics (NCHS) used in reporting and determine how well our linked file matches with the NCHS linked file. Any discrepancies will be addressed by the workgroup and changes made to the linkage algorithm as necessary. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Youth Tobacco Survey	3	No

Notes - 2010

Narrative:

Data from the most recent Youth Risk Behavior Survey (YRBS) show that fewer Kentucky high school students are engaging in negative behaviors than in 2003.

Developed in 1992, the YRBS includes national, state and local school-based surveys of representative samples of 9th- through 12th-grade students. These surveys are conducted every two years, usually during the spring semester. The national survey, conducted by CDC, provides data representative of high school students in public and private schools in the United States. The state and local surveys, conducted by departments of health and education, provide data representative of public high school students in each state or local school district.
In Kentucky, the YRBS is given to a randomly selected sample of high school students. The data is reported as statewide totals only.

Tobacco Use
The percentage of students who ever tried cigarette smoking has decreased from 71.1% in 2003 to 62.2% in 2007.

The percentage of students who smoked cigarettes on school property on one or more of the past 30 days has decreased from 14.3% in 2003 to 9.5% in 2007.

/2010/ High School current smokers 26.8% compared to 24.5% in 2006 (difference is not significant). Since 2000, high school smoking has declined 28%.

Middle School current smokers 9.7% compared to 12.1% in 2006, a decline of 20%. Since 2000, middle school smoking has declined 56%.

Smokeless tobacco use increased from 13% in 2006 to 14% in 2008 (high school) while middle school use remained the same.

In 2008, 30% of high school smokers more often gave money to an older person to purchase cigarettes rather than purchased them in a store themselves, borrowed, or bummed them from someone, or received from an older person without payment.

High school students who have been in a room with someone who was smoking within the past week decreased in 2008 for both never smokers and current smokers. In 2006, 67% (56% 2008) of never smokers were exposed to secondhand smoke with the past week. In 2006, 92% of current smokers were in a room with someone who was smoking within the past week, decreasing to 89% in 2008. //2010//

Smoking in middle school and high school students in Kentucky is decreasing.

Youth Advocacy Trainings: Raising youth awareness about smoking hazards and the impact students can have on reducing exposure

/2010/ Strategies
By 2014, decrease the percentage of high school students (grades 9-12) who report smoking cigarettes on one or more of the previous 30 days to 20% or less.

By 2014, decrease the percentage of middle school students (grades 6-8) who report smoking cigarettes on one or more of the previous 30 days to 10 % or less.

Strategies to meet these long term objectives include increasing youth advocacy activities including media events, web page hits, and success stories and starting a statewide campaign to get 100 percent of (K-12) public and private schools to adopt a comprehensive tobacco free environment policy consistent with the National School Board Association (NSBA) Delegate Assembly recommendations.

Current and Planned Activities

24/7 Tobacco-free Schools --We are working with Coordinated School Health and Kentucky ACTION (state tobacco control coalition) to educate local school boards and site-based councils on the need for 24/7 tobacco-free schools and assist them in implementing comprehensive policies.

PANTA Guide -- we will revise the PANTA (Physical Activity Nutrition Tobacco and Asthma) Guide to include the eight components of a Coordinated School Health Program. The Guide will be distributed to all Kentucky local health departments and schools.

Youth Advocacy -- Partnering with the Tobacco Prevention Enhancement Site, we offer grants to regional partnerships to hold conferences to engage youth in tobacco control advocacy. Stipends and additional funds are offered to school sponsors to work with the youth throughout the school year. We also host a web site for youth advocacy. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

Since the Public Health Improvement Plan in 1998, the Department for Public Health has maintained a strong emphasis on data for assessment of our strategies. The Public Health Improvement Plan from 1998 identified the following priorities:
-Teenage pregnancy and low birth weight babies
-Infant death
-Deaths due to heart disease, cancer, and stroke
-Health issues related to a rapidly growing elderly population
-Immunizations for children
-Disability and premature death of children and youth
-Lifestyle activities, including physical fitness and exercise, nutrition, sexual practices, use of tobacco, alcohol, and illegal substances, and seat belt use
-Prenatal care for pregnant women
-Access by both private and public health providers to health and health-related information
-Environmental health standards
-Food safety
-Communicable diseases

Kentucky DPH continues to monitor Performance Measures and related measurable health outcomes on a regular basis. March of Dimes Peristats data, BRFSS, Healthy People 2010, Healthy Kentuckians 2010, state vital statistics data, Medicaid data, and WIC data are used as baseline data to develop program goals, objectives and strategies and then to track health outcome indicators. Data analysis is an integral part of Kentucky's MCH program evaluation process, and the Title V Block Grant National and State Performance Measures are critical to that process. A concerted effort was made to provide detailed program information for each activity that addresses a national or state performance measure.

/2007/ The Kentucky Department of Public Health conducted a Mid-Decade Review of the Healthy Kentuckians 2010 report. Among the HP 2010 MCH indicators where KY has shown progress are:
-decreasing infant mortality
-decreasing fetal death rate
-decreasing perinatal mortality rate
-increasing early entry and adequate prenatal care (prior to change in data source)
-increasing proportion of mothers breast feeding
-lowered incidence of neural tube defects
-increased percent of women taking folic acid
-increased the number of pregnant substance abusers admitted into treatment programs
-reduced the number of children with serious neurological/sensory impairments
-increased the number of newborns screened for hearing disorders.
-increased the use of child restraints (kids <4)
A summary and the full report may be viewed at chfs.ky.gov/dph/hk2010MidDecade.htm //2007//

/2009/ Kentucky's priorities continue to be the health, safety and well-being of women, infants and children. The priorities are much the same as in the last 10 years. However, after review of the data, we are acknowledging that there has been little improvement in the health of Kentuckians despite our efforts, which have included large scale promotion of evidence-based strategies to address issues at the community level. Dr. Hacker has therefore selected a limited number of topics to be our primary focus, although no current programmatic area will be ignored. The topics selected for emphasis will be 1. Unhealthy lifestyles - primairly related to obesity and physcial activity 2. Tobacco use, including smoking during pregnancy; 3. Mental health issues including suicide and substance abuse, 4. preventable injuries (leading cause of death age 1-44), and 5. Oral Health.

Details of these efforts are provided in the measures throughout this grant.

The Department for Public Health is already participating in regional meetings regarding the development of national 2020 objectives, and those that are relevant will help set the priorities for Kentucky in the future. //2009//

Both the Commission for Children with Special Health Care Needs and the Department for Public Health welcome questions from readers. Contact information for the main offices of both agencies are listed below. Upon receipt of your call, you will be connected to the appropriate staff.

Kentucky Department for Public Health, Division Maternal and Child Health 502-564-2154

Kentucky Commission for Children with Special Health Care Needs 502-595-4459

B. State Priorities

State-Level Priorities

Obesity and Inactivity: Kentucky began its efforts to combat obesity in 2004 with a series of community forums around the state.
The top six priorities from these forums were:
1. Provide mandatory physical education for K-12
2. Increase healthy choices in vending machines
3. Improve worksite policies to allow time to exercise, health seminars, and flex time
4. Provide more safe walkable communities and bike paths
5. Provide more staff for breastfeeding support
6. Lower the cost of fruit and vegetables

These were compiled with relevant data into a burden document for the use of legislators and administrators then put into a state plan to address obesity and physical activity, which was produced in 2005. The plan was developed through a collaborative partnership of community and state level persons interested in promoting obesity prevention and physical activity. This group, the "Partnership for a Fit Kentucky", continues today. More information can be found on their web site.

Senate Bill 172 in the 2005 General Assembly improved Kentucky's school nutrition. Kentucky was recently identified as having the best school nutrition policy in the United States by the Center for Science in the Public Interest's (CSPI). The CSPI evaluation of policies for foods and beverages that are sold in schools through vending machines, school stores, fundraisers and a la carte lines gave Kentucky the only "A" in the nation.

Through a collaborative effort among the Tobacco Control, Physical Activity, Obesity Prevention, and Coordinated School health staff, a guide for school administrators was developed and distributed by the Kentucky Department of Education. The "PANTA" Guide covered school assessment, evidence-based strategies, resources, and policy development for Physical Activity, Nutrition, Tobacco, and Asthma.

In 2006, the Governor created an Office of Wellness and Physical Activity (GOWPA), pulling the Public Health programs and personnel for those issues into a single unit. This group developed a web site to engage Kentuckians similar to the President's Challenge, as well as continuing the activities of each of the programs.
After the change in administrations, the GOWPA group was moved back to Public Health into the Chronic Disease Prevention Branch of the Division of Prevention and Qualtiy Improvement.

The new Cabinet Secretary, Secretary Miller, and Dr. Hacker both have an interest in moving the empahsis to prevention of childhood obesity. Dr. Hacker attended a recent CDC summit on Obesity Prevention and the Law. Staff are working with Save the Children Organization for a summit on Childhood Obesity in Kentucky later this summer. Dr. Hacker and Representative Wuschner have obtained grant money from the National Governor's Association to host a summit on childhood obesity in the spring of 2009 aimed at the legislative and policy level. ***/2010/ The policy summit was held in May, 2009 and attended by over 150 people from several states. The report of the workgroup can be found at www.fitky.org //2010//***

The CCSHCN participates in numerous public education initiatives that address childhood obesity. A Commission employee sits on The Partnership for a Fit Kentucky planning committee which focuses on promoting good nutrition and encouraging communities to become physically active. The WE CAN! Initiatve is an outreach program designed to reach children 8-13 years of age and their parents. Recently, we have partnered with Pennyrile Allied Community Services, Inc. to provide a monthly newsletter that promotes healthy lifestyles. //2009//

The Tobacco Control Program's mission is to reduce the amount of disease and deaths related to the use of tobacco among Kentuckians. Initiatives are based on the CDC Best Practices for tobacco control: preventing youth initiation, promoting quitting among adults and young people, eliminating exposure to secondhand smoke, and identifying and eliminating disparities among population groups disproportionately affected by tobacco use. Efforts began with Community Forums on Tobacco Use in Kentucky, August 2005 -- November 2005; from those forums, the top five priorities for the state were:
1. Smoke-free ordinances
2. Increase the excise tax
3. Tobacco-free schools (100% tobacco-free campuses including extracurricular activities, buses, and athletic fields)
4. Insurance coverage for Nicotine Replacement Therapy (NRT) and prescription pharmacotherapy, tobacco cessation counseling and programs
5. Smoke-free worksites

Many initiatives have followed since these priorities were set. Kentucky currently has 17 communities with smoke-free ordinances. Patients/clients who are seen in any of these programs were screened to identify those using tobacco: Prenatal; Family Planning; HANDS; WIC; Nutrition; Adult preventative care; Pediatric Preventative care (Well Child); and Cancer. Every LHD continues to offer smoking cessation programs/classes, that are available to anyone referred by self or from doctor's offices or other community agencies.

Free nicotine replacement therapy was provided for Medicaid recipients who were actively enrolled in counseling with Kentucky's Tobacco Quit Line. The Pilot was a joint project between Medicaid, Public Health and the Tobacco Program for the period is March 1-December 31, 2007. Preliminary data showed a 66.84% quit rate at one month. Evaluation included quit rates for 3 months, 6 months, and 1 year.

Kentucky's Tobacco Quit Line 1-800 QUIT NOW. The Kentucky Tobacco Quit Line is an evidence-based tobacco treatment program and wonderful resource for the Commonwealth. The Quit Line offers individualized cessation counseling for all tobacco users, including spit and chew tobacco, and a specialized protocol for pregnant women who smoke. English and Spanish language counselors are available. A TDY/TDD toll free number is available for individuals who are deaf and hard of hearing: (800) 969-1393. The Quit Line also provides referral information to connect callers with people in their community who can help, such as local and district health departments.

The Tobacco Program engaged partners to develop the Hospital Inpatient Tobacco Treatment Pilot to increase inpatient treatment for tobacco use. Partners are American Heart Association, Kentucky Hospital Assn, Kentucky Cancer Program (University of Louisville), and Healthcare

Excel. Components include a baseline survey of hospitals, the selection of 5 pilot hospitals; standing orders for nicotine replacement therapy and other pharmacotherapy, standardization of materials and referrals, and evaluation.

Among all women 18-44 in Kentucky, about 1 in 3 smoke. Overall 23.9 % of Kentucky's pregnant women are smoking during pregnancy, so there is some impact of the message not to smoke during pregnancy. KY has the second highest rate of women who smoke during pregnancy, 23.9 %, compared to the national average of 10.7 %. Only West Virginia has a higher rate. Our lowest rate by county was still well above the national average. Our highest rate for a county was 45.8 %. Rate of smoking in pregnancy has not changed significantly over the last 10 years. The MCH and Tobacco Control program are partnering in new initiatives to address smoking in pregnancy. (see NPM 15)
Program provided Treating Tobacco Use and Dependence and Treating Tobacco Use and Dependence during Pregnancy self-study kits to Kentucky physicians, dentists, nurse practitioners/midwives, physician assistants, dental hygienists and psychologists upon request.

Tobacco Program staff are ex officio members of the KY Medical Association, Committee on Community and Rural Health and have completed several projects with Committee members. The projects are designed disseminate information and to assist physicians in counseling patients.

/2009/ Due to Kentucky's financial distress, Governor Beshear proposed during the budget talks that Kentucky raise the tax on cigarettes to $.75 - still much lower than the national average, but higher than our current tax. This proposal was supported by editorials and advocacy groups, but failed to pass the legislature. //2009//

State MCH Priorities

Kentucky is building its MCH capacity for data collection and analysis in order to support data-driven and evidence-based decision making. Staff development through trainings, and skill building thru projects are a priority. A number of initiatives to that end are underway:

/2010/ The Pregnancy Risk Assessment Monitoring System (PRAMS) Pilot Project

The Pregnancy Risk Assessment Monitoring System (PRAMS) was established in 1987 by the Center for Disease Control and Prevention (CDC). The purpose of this population-based surveillance system is to obtain information pertaining to maternal behavior and experiences that may be associated with adverse birth outcomes. The survey is disseminated to women that have recently given birth to live born infants. Thirty-seven other states currently participant in PRAMS and provide data to the CDC for a national report.

In the Fall of 2007, the Kentucky Department for Public Health Division of Maternal and Child Health (MCH) conducted a PRAMS Pilot Project following the CDC PRAMS Protocol. A random sample of Kentucky residents, which were derived from the birth certificate files, who delivered a live born infant were selected to complete the survey through mail or telephone. In Spring of 2008 data collection was completed with an overall weighted response rate of 62.15% (which is comparable to the first year of some CDC funded states). The results from the pilot project can be found in the Kentucky PRAMS Report which can be found on the Kentucky Department for Public Health website. Below are a couple of findings:

-28.8% of the Kentucky PRAMS mothers did not have any health care coverage
-40% of the mothers that reported their pregnancies being unintended were uninsured

Under the CDC PRAMS protocol it is recommended that each state has a weighted

response rate of 70%. Because our first pilot project was such a success, the Division of MCH decided to conduct a second PRAMS project which began in April 2009. For this we are partnering with UK Dept of OB-Gyn, who will oversee and conduct the phone portion of PRAMS. //2010//

ECCS Grant

The Early Childhood Comprehensive Systems grant examines current services and identify potential service gaps within five areas Early Childhood Development; Health Insurance/Medical Home; Mental Health/Social-Emotional Development; Early Care and Education Child Care and Parent Education and Family Support. Each subcommittee will meet to discuss issues and provide recommendations.

/2007/ The Early Childhood Comprehensive Systems grant is currently in its first year of implementation. The efforts for this implementation year are focused on filling identified "gaps" in services to young children within the existing KIDS NOW Initiative. Kentucky's Early Childhood Mental Health Program was showcased in a workshop at the AMCHP Annual Conference in March 2006. This program has been identified as a "model program" for early childhood mental health services. To date, the majority of activities listed in the grant have been completed. //2007//

/2009/ The Early Childhood Comprehensive Systems grant is in its final implementation year. The efforts for this implementation have focused on filling identified gaps in services to young children within the existing KIDS NOW Initiative. The funds from this grant have successfully carried out the mission of the Healthy Child Care America program by maintaining 1.5 FTE statewide trainers for childcare health consultation. Furthermore, the SECCs funds have been instrumental in securing early childhood mental health training and supervision, along with data collection and evaluative efforts around KIDS NOW programming. The programs supported through this grant will be sustained and funded through the Kentucky KIDS NOW initiative. //2009//

/2010/ The guidance for the ECCS grant changed significantly this year to emphasize building of systems. Kentucky already has systems in place, mostly funded thru Tobacco Settlement money, but applied for the grant in order to identify gaps and include more partners. A copy of the application is attached because it is a good summary of the early childhood systems existing in Kentucky. //2010//

SSDI grant

/2008/ Kentucky completed a renewal for the State Systems Development Initiative (SSDI) grant this year, and received funding for five years. This grant has two major goals: 1) Increase collaboration and data capacity within the Department for Public Heath through data linkages and data integration of selected early childhood programs; and 2) Increase maternal and child health epidemiologic and health informatics capacity within the Division of Adult and Child Health Improvement to improve surveillance and analysis of selected early childhood outcomes as well as program evaluation. Kentucky continues to provide funds through a contractual relationship with the University of Louisville, School of Public Health and Information Sciences for the purpose of data linkage and integration support of selected early childhood systems. A great deal of effort has been focused this year on the linkages within the Kentucky Birth Surveillance Registry (KBSR). This data system integrates hospital discharge data and vital statistics data (live births, stillbirths and deaths) to monitor the occurrence of birth defects in the Commonwealth of Kentucky. In 2004, the live birth certificate was changed in Kentucky, and these linkage efforts have focused on incorporating this new certificate and its additional fields within the KBSR system. An abstract describing these linkage efforts are being submitted for the 2007 Maternal and Child Health Epidemiology Conference.

In the upcoming year, the SSDI will continue these projects and begin to link Vital Statistics data with the HANDS (Health Access Nurturing Development Services) Home Visitation Program and First Steps. In addition, a quality assurance program for the Kentucky Birth Surveillance Registry will be developed and piloted. //2008//

/2009/ SSDI funds have also been utilized to hire an epidemiologist in the Division of Maternal and Child Health. This individual will collaborate with the University of Louisville staff on data linkages. In addition, this individual has organized a Pregnancy Risk Assessment Monitoring System (PRAMS) pilot project in Kentucky.

For 2010, the SSDI grant will continue focus on linking Vital Statistics data with the HANDS (Health Access Nurturing Development Services) Home Visitation Program using Link Plus, and, if succesful, develop a similar linkage for our Part C Early Intervention program. In addition, the University of Louisville will be providing training on statistical methodology and its application including familiarity with SAS for state staff. //2009//

/2010/ Kentucky is currently in year three of a five year State Systems Development Initiative (SSDI) grant period. This grant has two major goals: 1) To increase collaboration and data capacity within the Department for Public Heath through data linkages and data integration of selected early childhood programs; and 2) To increase maternal and child health epidemiologic and health informatics capacity within the Division of Adult and Child Health Improvement for the purpose of improved surveillance and analysis of selected early childhood outcomes as well as program evaluation.

Kentucky continues to provide funds through a contractual relationship with the University of Louisville, School of Public Health and Information Sciences for the purpose of data linkage and integration support of selected early childhood systems. Efforts in the current year have focused on linkages between vital statistics (live birth, stillbirth and death certificates) with data from Kentucky's home visitation program, Health Access Nurturing Development Services (HANDS).

SSDI funds have also been utilized to provide financial support for an epidemiologist in the Division of Maternal and Child Health. Currently, this individual is coordinating a Pregnancy Risk Assessment Monitoring System (PRAMS) pilot project in Kentucky. SSDI funds are being used to extend this project an additional two months.

In the upcoming year, the SSDI grant will focus on two linkage projects. The first will be the development of a linked birth-death file; a file of use to numerous programs. The second project will use Link Plus to develop an algorithm to link birth certificate and hospital discharge data. Due to the limited funds available, the contract with the University of Louisville will be discontinued and all linkage projects will be completed within the Division. Kentucky will also continue to seek pertinent data trainings to enhance the epidemiologic capacity of staff. //2010//

Epi Capacity

/2008/ A memorandum of agreement was negotiated with the Centers for Disease Control and Prevention for a Senior MCH Epidemiologist assignee. We have also reclassified an existing position in the Early Childhood Development Branch to an Epidemiologist I position. The availability of trained staff to complete data analyses and evaluate program effectiveness will significantly improve the programs within the Early Childhood Development Branch. /2009/ Although it was expected that a Centers for Disease Control and Prevention (CDC) Senior MCH Epidemiologist assignee was going to be assigned to Kentucky, this has not occurred to date. //2009// ***/2010/ The CDC Assignee came in Sept 2008. The Epi position in Early childhood has been filled, as well as an epi position for the Oral Health Program. The "MCH Epi team" meets weekly to discuss projects and possible collaborative efforts.***

Other MCH Priorities/ Program Activities

Preterm Birth

"Healthy Babies are Worth the Wait" is a 3 1/2 year initiative begun by the Department for Public Health in 2007 and is a partnership with National March of Dimes and Johnson & Johnson Corporate Contributions, who fund as well as participate in the project. The design is a "real world", ecological design as a demonstration project, not a linear cause and effect study. We have identified 3 intervention sites with geographic diversity and different health care settings (university, private practice, and clinic-based) to achieve 1200 births in the three years. The outcomes from these sites will be compared with 3 similar sites where we do no intervention. The intervention is multidimensional, taking evidence-based practices to prevent preterm birth, and link elements of clinical care, public health, and consumer & public education in the intervention communities. The target, based on Kentucky's data analysis, is late preterm birth (34 0/7 weeks to 36 6/7 weeks), and the elements of preterm birth that may be preventable. The goal is a 15% reduction in preterm birth in the intervention sites. More information can be found at the web site www.prematurityprevention.org.

/2009/ The Children Ready to Read for Health
This program works with pediatric providers to help raise pre-reading skills among young children of low income, so they begin school ready to learn. Children Ready to Read for Health promotes language and literacy by giving parents guidance about reading aloud to their children and providing developmentally appropriate books to take home at each pediatric visit from 6 months to 5 years. Age-appropriate books and parental advice on book sharing are given by nurses and doctors. The program provides training and technical assistance in the implementation of the program. Research shows that 16% of parents of children age three years and younger do not read at all with their children, and 23% do so only once or twice a week; percentages are lower among low-income families, whose children face the highest risk of literacy problems.

According to KY Kids Count, 21% of children in Kentucky are born to mothers without a high school degree and 21% of all children are in poverty. The program provides information about the value of reading to children. Families living in poverty often lack the money to buy books. Parents who may not have been read to as children themselves may not realize the value of reading to their own children. The program supports local, community-based efforts to enhance the early language, literacy, and prereading development of preschool-age children, particularly those from low-income families, through strategies and professional development that are based on scientifically based reading research.

Higher levels of reading and literacy help reduce costs for special education, decrease costs of unemployment and low wages, decrease health care and crime costs. Higher literacy correlates with the percentage of adults employed in professional and related occupations and management, business, and financial occupations than in other occupations. Women with higher levels of literacy are less likely to receive public assistance than women with low levels of literacy. Additionally, enhanced early childhood intervention programs have been found to save 4 dollars for every 1 dollar spent. //2009//

/2010/ Prior to the program Kentucky had 20 sites. Since December 2007, we have added 27 sites, located in counties with the state's lowest literacy rates. Kentucky's 46 sites have provided 26,286 books over the last 6 months with 56% of books given out at sites added since December 2007. Kids Now funding has provided at least half of the book budgets for both new and existing sites, in 29 counties throughout the state. Currently, seven sites from seven different counties are applying to become sites. Sites must be able

to fund 50% of their book budgets before they will be approved by the National Center, and because of the Kids Now funding, sites in Kentucky continue to be approved. //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	95.5	96	98	98	99
Annual Indicator	83.6	98.4	98.5	97.6	99.2
Numerator	46	380	534	526	711
Denominator	55	386	542	539	717
Data Source					KY Newborn Screening Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99.2	99.5	99.5	99.5	99.6

Notes - 2008
2008 data is preliminary and numbers could change.

a. Last Year's Accomplishments
/2010/ This program administers the newborn metabolic screening for all infants born in Kentucky. All newborns in Kentucky are screened for metabolic and genetic conditions that can have serious adverse outcomes if untreated early in life. Early detection, diagnosis and treatment of children with these rare metabolic conditions may prevent a child's death, disability, or serious illness. In 2006 newborn screening in Kentucky was expanded to include the full panel of 29 tests for inborn errors of metabolism and other inherited disorders, recommended by the American College of Medical Genetics and the March of Dimes. In September 2008, 20 secondary conditions were added to Kentucky's screening panel to total 49 disorders.

The newborn screening follow-up team consists of a nurse administrator, two nurse consultants and a program coordinator. Newborn screening tests are performed by the Kentucky Department for Public Health, Division of Laboratory Services. Follow-up for positive screens is coordinated by the newborn screening follow-up team in the Division of Maternal and Child Health. This team assures follow-up of all abnormal screens for definitive diagnosis and treatment for inborn errors of metabolism and inherited disorders included on the newborn screen. Short term case management is carried out by follow-up staff using the infant's primary care provider as the medical home to coordinate definitive diagnosis. This staff is cross-trained to work with the birth defects registry as well.

Additionally, contracts exist with both the University of Kentucky and the University of Louisville Medical Centers to provide medical consultation. Upon receiving a confirmatory diagnosis of the screening result, the university medical centers engage in patient/family education, medical management and training throughout the state. Formula and food products, as well as supplements are also provided for individuals with metabolic conditions when a third party payer source is unavailable.

Beginning January 2008 enhancements were made to the Newborn Screening data system, within the Cabinet for Health and Family Services to allow interfacing with the vital statistics electronic birth certificate at the birthing hospitals. The case management segment of newborn screening has been developed as part of the KY-CHILD Electronic Public Health Record Set. The birthing hospital enters the demographic information and prints a label to affix to the newborn screening specimen collection card and mails to the state lab for testing. The labels contain a unique bar code on them. The demographic information is interfaced with the Newborn screening case management system for case management of infants with abnormal screening results. The system now has the reporting capability of producing a report of possible missed screens by cross checking the KY-CHILD system and verifying a newborn screening label was completed on the infant. If a label is not completed the infants name appears on the report and follow-up staff contacts newborn screening coordinators at the facilities for more information on infant.

In addition to the report above, the state laboratory implemented the specimen gate laboratory information system from PerkinElmer in December 2008. This system allows for scanning of the bar-coded labels into the lab system which automatically loads the demographic information directly from the KY-CHILD system. This produces less potential for errors in data entry. With this system there are also now several quality assurance reports that can be run on a monthly basis or on demand. These reports include timeliness from collection to receipt at the state lab and the percentage of unsatisfactory specimens by facility. These reports allow the follow-up team to target those facilities that are need of improvement.

Educational trainings for providers on the newborn screening and specimen collections have been updated this year and are available on-line. On-site trainings and education have also been provided.

902 KAR 4:030 established that each birthing facility designate a newborn screening coordinator to the Department for Public Health (DPH). This coordinator works with the follow-up staff to assure that every infant born at their facility receives a newborn screen and appropriate follow-up. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Newborn Screening program was expanded to a total of 49 disorders with the addition of 20 secondary conditions.			X	X
2. Enhancements made to the newborn screening data system to allow interfacing with the vital statistics electronic birth certificate at birthing hospitals using a bar code.			X	X
3. PerkinElmer specimen gate laboratory information system implemented to allow for scanning bar-coded labels into the lab			X	X

system, automatically laoding the demographic information directly from the KY-CHILD system.				
4. Educational trainings for providers on newborn screening and specimen collections have been updated and are available online.	X	X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ Monitoring is done monthly on specimen collection to receipt by the lab and percentage of unsatisfactory specimens received. The program plans to run the timeliness from collection to receipt by the lab and unsatisfactory specimens percentages to produce a report comparing each hospital to the rest of the state and giving them a feedback report. Reports will be distributed to hospital administrators, risk managers and newborn screening coordinators. The follow-up team will work with facilities to improve individual performance thereby improving the overall system process.

Establish a registry for DNA mutations identified in infants diagnosed with Cystic Fibrosis (CF). From January 2006 to May 2009 28 different mutations have been identified. The state laboratory is evaluating the need for a second tier test for CF on the newborn screen to include DNA testing on presumptive positive screens.

The program maintains updates for the 49 primary and secondary disorders and informational fact sheets and resources for health care providers and parents. These education materials were also made available on the website http://chfs.ky.gov/dph/ach/newbornscreening.htm .

Kentucky currently participates in a HRSA Regional Genetic and Newborn Screening Collaborative Grant in Region 4. and is assisting in the development of both short term and long term protocols and treatment methods with the other states in the collaborative. //2010//

c. Plan for the Coming Year

/2010/ 902 KAR 4:030 established that each birthing facility designate a newborn screening coordinator to the Department for Public Health (DPH) and submit a newborn screening protocol annually. The newborn screening staff will continue to work with birthing facilities to develop a newborn screening protocol which assures that every baby born receive a newborn screening test until 100% have compliant protocols..

Provide feedback to the hospitals on the quality and timeliness of newborn screening testing based on their current 2008 data. Work with birthing hospitals on quality improvement regarding the screening process to include establishing a protocol to assure every newborn receives a screen and the procedure for reporting if a parent refuses to allow screening. Establish preliminary prevalence rates for the newborn screening disorders for the 2006, 2007 and 2008 data in Kentucky.

Develop a care notebook for parents of diagnosed infants. That would serve as a portable medical record for parents with information about the disorder and treatment and other pertinent information about the infant.

NBS is working with the early intervention program to establish a referral process for children identified through screening as having an established risk condition that is automatically eligible for early intervention services. A letter has been developed that universities can give to parents explaining the program and services available for their child and contact information. The point of entry for early intervention will also be notified at the same time. This project will be piloted with one condition and evaluate parent response to services.

The PerkinElmer laboratory information system will begin development and implementation of a web-based physician module. This will allow health care providers in the field to access and print newborn screening result reports.

Infants diagnosed as positive for disease through newborn screening will be fully integrated into the birth defect surveillance registry for long term tracking and future reporting. These will be imported into the birth defects registry upon completion of the annual reporting.

The HRSA Region 4 Genetics and Newborn Screening Collaborative received a new award which will extend through the next three years and Kentucky will continue to participate in the initiatives of this grant.

Increase the percent of newborns screened to 99% from the current 98%. Analyze data for percent of newborns screened and establish baseline of number of screens refused by parents. Provide education to parents and hospitals on NBS and its importance, as well as the simplicity of the screening process. Targeted education to home births reported to vital statistics is planned to evaluate effectiveness in increasing the number of newborn screens performed on home births. The follow-up team will develop parent letter and establish protocol for these home births to overcome refusals. //2010//

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	63	65	67	67	68
Annual Indicator	61.3	65.1	69.3	64.1	62.5
Numerator	5651	5560	6141	5261	3999
Denominator	9214	8543	8862	8206	6398
Data Source					CCSHCN Database (FY 08)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69	70	70	70	70

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN database for FY 2007-2008. Age group used for this PM is 3-18 as KY utililzes transition checklist information for the numerator; and the transition checklist is primarily completed for children age 3 and older.

The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
/2010/ The Parent Advisory Council (PAC) provided guidance to parents of CSHCN whether or not they were enrolled in a CCSHCN service. Meetings were focused on developing advocacy and parent-to-parent skills, as well as parent-with-community skills. Programs presented at PAC meetings included emergency preparation, music therapy, and working with state legislators. The PAC reviewed the exit process and reviewed home instruction sheets. Parents were given opportunities to make suggestions on how the process can be improved. PAC participated in Region 4 Genetic collaborative in finding families to serve on the transition, medical home, and care coordination teams when they were unable to find families in Kentucky to serve.

The Youth Advisory Council (YAC) continued to build relationships among CYSHCN, regardless of their affiliation with the CCSHCN. YAC meetings focused on understanding their role in the health care process and becoming a partner in making decisions regarding the services they receive.

The YAC and PAC advocated for and supported the passage of the anti-bullying bill, HB 91; and one member of the YAC attended the Governor's signing of HB 91.

Resources are available for families with limited English proficiency, which allow the CCSHCN to further partner in decision making at all levels. Families who do not speak English as their first language are provided interpreters for all clinic and non-clinic visits to the CCSHCN. Written materials are translated so that families with limited English proficiency have access to all forms and documents utilized by CCSHCN. The Cabinet for Health and Family Services provides voice mail interpretation and calls can be made to families who do not speak English through a third party interpretation service. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Parent Advisory Council meets regularly and open to all KY parents of CSHCN. Transportation expenses are reimbursed.		X		X
2. Youth Advisory Council meets regularly and open to all KY CYSHCN. Transportation expenses are reimbursed.		X		X
3. Youth Advisory Council advocated for and supported the passage of HB 91 (Anti-Bullying Bill).		X	X	
4. CCSHCN acts under the advisement of a Board of Commissioners, as well as several program specific advisory boards.		X		X
5. CCSHCN employs parents of CSHCN as family consultants.		X		
6. Interpreters are available for families of children who are limited in English proficiency and enrolled in CCSHCN services during clinic and non-clinic appointments.		X		
7. Information about CCSHCN and CSHCN services are available on the CCSHCN website (in English and Spanish)	X	X	X	X
8.				
9.				
10.				

b. Current Activities

/2010/ The Parent Advisory Council (PAC) continues to provide input to the Commission and share their expertise with other families. The PAC continues to provide training regarding new programs and services available to families. The PAC continues to partner with any organization that can improve the services and or satisfaction with those services for our families; and the PAC is always looking for openings for families to provide their input and participate in decision making.

Clinic notes reflect discussions with families regarding treatment decisions and options, as well as the families' input. As well, the Commission continues to utilize and monitor a toll-free consumer call line for family comments and complaints.

One of the CCSHCN family consultants attended the AMCHP conference as a Family Scholar.

The CCSHCN is planning and conducting Five Year Needs Assessment Surveys; heavily involving all families with CSHCN in KY. Parents and youth have been involved in the creation and review of the statewide family survey, which is being conducted by paper, telephone and online this summer.

The CCSHCN is taking the first steps in developing family relationships through community collaboration with funds from the Family to Family Health Information Center (HIC). The HIC builds on an existing network of family advocates in partnership with the state-wide network of Title V CYSHCN services. They will be managed by two parents of CSHCN and involve the CCSHCN PAC. //2010//

c. Plan for the Coming Year

/2010/ The Parent Advisory Council will continue to develop and begin to provide guidance through our new Family to Family Health Care Information Centers. The centers will be directed by parents of CSHCN who also have experience in federal and state, public and private health care systems and providers. Information, education, technical assistance and peer support will be accessible to families; including education on parterning with providers to increase prominence in role of health care decisions.

The Commission will continue to work with families to provide education and assistance in developing independence toward health care decision making.

The Board of Directors will continue to provide guidance and insight in addressing the needs of the special needs population, including our foster care support and medically fragile foster care system.

Information from the Five Year Needs Assessment surveys will be analyzed, prepared for the 2011 Block Grant Application, and reviewed to assess CCSHCN goals and objectives.

Commission staff will continue to provide interpretation and translation services to families with limited English proficiency. The agency will collaborate with the Cabinet for Health and Family services to remain current on Federal and State expectations pertaining to Title VI and Limited English Proficiency laws.

The CCSHCN staff will continue to partner with community agencies, schools and other community networks to identify and address service needs of the CYSHCN population.

The CCSHCN will continue to operate the consumer call telephone line, through which families can voice praise and concerns regarding the services they receive. //2010//

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	95	95	95	92	93
Annual Indicator	90.4	90.1	90.0	91.3	91.9
Numerator	8327	7699	7976	7618	7606
Denominator	9214	8543	8862	8343	8277
Data Source					CCSHCN Database (FY 08)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	93	94	94	95	95

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN database for FY 2007-2008.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
/2010/ The CCSHCN continued to identify each child's PCP and place the information into the CCSHCN database system. The Commission worked with each child's PCP and other providers associated with the medical home to share medical information with regards to HIPAA guidelines.

In a joint effort with the University of Kentucky, the Commission established the Medical Home for Coordinated Pediatrics (MHCP). Located within the Lexington regional office, the MHCP serves central Kentucky children in the foster care system by providing comprehensive primary care to those who do not have a designated PCP. This includes well-child checks, immunizations, development assessments and specialty care, if needed. For children who do have a PCP, the MHCP provides resource information to providers about referrals and specialists.

Through a Memorandum of Understanding with the Department for Community Based Services, the CCSHCN Foster Care Support Branch continued to coordinate programs which ensure the the immediate, ongoing and preventative health of children in the child welfare system. For children who are in the foster care system and are also determined to be medically fragile, CCSHCN Nurse Consultants provided consultative services for foster parents and the social workers.

The Nurse Service Administrators continued reviewing patient medical charts for issues pertaining to documentation and care coordination. The audit process prompted changes in position descriptions and performance plans to ensure a uniform process of care coordination for children enrolled in CCSHCN services statewide. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Primary care physicians are identified for each child and documented in database.				X
2. CCSHCN provides medical specialty care in collaboration with child's medical home.	X			
3. Children are able to see multiple specialists in one visit to clinic.	X			
4. The Foster Care Support Branch collaboration with DCBS allows for the coordination of medical services for children in the foster care system.	X	X		
5. The Medical Home for Coordinated Pediatrics in Lexington provides primary care for children in the foster care system who do not otherwise have a primary care physician.	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ It is one goal of the CCSHCN to ensure that all patients have an active primary care physician. CCSHCN staff continue to verify that each child has a PCP and strives to coordinate primary care services for those who do not have a designated provider.

The foster care program continues to collaborate with state social workers to ensure that ongoing, preventative health services are met for the foster care population. The Medical Home for Coordinated Pediatrics continues to provide primary care for central Kentucky children in the foster care system.

The CCSHCN continues to hold on-site clinics at which patients can see a multi-disciplinary team of specialists in one visit, as well as consult with a social worker. Medical and treatment information is shared with the patient's PCP and other providers associated with the medical home with regards to HIPAA guidelines. Patient medical care is coordinated by staff nurses; and audits of medical records to ensure a uniform system of care continues. //2010//

c. Plan for the Coming Year

/2010/ The CCSHCN will expand the role of the Medical Home for Coordinated Pediatrics (MHCP) by conducting regular case conferences for children served with social workers from the Department for Community Based Services (DCBS) to discuss treatment plans.

The CCSHCN will continue to verify that each child has an active primary care provider. The agency will partner with other providers associated with the child's medical home to provide a continuous system of health care, with regards to HIPAA laws.

The CCSHCN will continue to collaborate with DCBS staff to ensure continuity of care for the state's foster care and medical fragile foster care population.

The CCSHCN will review the number of CYSHCN who are enrolled with medical Passport services and increase access to those services, as needed.

Nurse Service Administrators will continue to review medical records to ensure appropriate documentation has been made, as well as ascertain that services are coordinated, ongoing and comprehensive. //2010//

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	64.9	65	93	93	99
Annual Indicator	63.0	91.0	89.8	92.4	94.0
Numerator	6247	7778	7962	8125	8210
Denominator	9913	8543	8862	8791	8733
Data Source					CCSHCN Annual Report for FY 08 and CCSHCN Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99	99	99	99	99

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN Annual Report for FY 2007-2008 (numerator) and CCSHCN Database (denominator). Age group used for this PM is 0-21 as previous year information is not available in 0-18 sub-group for numerator.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
/2010/ CCSHCN staff received KCHIP training to remain current on application procedures. This information was shared with families, making it possible for them to apply for KCHIP coverage without needing to schedule an appointment or miss work. The goal of this training was to increase the number of families who were eligible for KCHIP benefits, but not enrolled in the program.

Patient eligibility for insurance coverage was verified at office visits. Insurance information is documented in the patient's record. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CCSHCN staff document and the insurance status in the electronic data system.				X
2. CCSHCN staff received KCHIP training.				X
3. CCSHCN educates families about their insurance coverage and seeks additional sources of payment for services for which the family may qualify.		X		
4.				
5.				
6.				
7.				
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9.				
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b. Current Activities
/2010/ The CCSHCN has initiated a plan to review cases in more detail to determine what, if any, additional resources can be utilized to assist in the coverage of services. Children who are in a 0% pay category and do not have insurance are referred to the KCHIP

program to complete an application. Children who are in a 0% pay category and do have insurance coverage are referred to the Medicaid program to complete an application. Staff monitor progress of Medicaid applications through the Kentucky Health Choices website.

An inter-agency system of community resources has been created for use by staff. This will allow staff to refer families to other resources already designed to provide services, such as The Lions Club for eyeglasses and Shriner's Hospital for orthopedic devices. Most patients who are diagnosed with Cystic Fibrosis have been referred for financial assistance to resources such as the CF Foundation and Needymeds.com. CCSHCN staff are referring families to pharmacies that will provide medications free of charge, or at a reduced rate. Kroger, Meijer and Wal-Mart are pharmacies that provide this service and are generally available statewide.

Questions pertaining to insurance coverage are included in the KY Children with Special Health Care Needs Five Year Needs Assessment survey. //2010//

c. Plan for the Coming Year
/2010/ Insurance information will continue to be documented in the CCSHCN electronic data system.

The CCSHCN will continue to monitor new applications and records of active patients to determine what resources may be available to assist in the payment of services.

The CCSHCN will continue to review applications and make referrals to the KCHIP and Medicaid programs for families who are in a 0% pay category and do not have any or adequate insurance.

Staff resources will be expanded as to maximize agency ability to refer families to existing resources.

The Commission will review new legislation pertaining to insurance coverage resulting from divorce decrees to see how families can benefit.

The Commission will utilize Family to Family Grant funding to increase discussions within and among families regarding insurance coverage and options.

Information received from the Needs Assessment survey will be analyzed, reported on the 2011 Block Grant application and considered for future CCSHCN goals and objectives. //2010//

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	77	78	93	93	93
Annual Indicator	81.2	91.1	89.8	92.9	95.5
Numerator	7484	7781	7961	7749	7901
Denominator	9214	8543	8862	8343	8277
Data Source					CCSHCN

					Database (FY 08)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	96	97	97	98	98

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN database for FY 2007-2008.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
/2010/ Families with children who require services from a multi-disciplinary team during a clinic visit were scheduled to see multiple specialists in one visit.

The CCSHCN employs two parent consultants who work in the Louisville and Owensboro offices. They regularly met and corresponded with families in an effort to listen to the needs of families with CSHCN, support families in becoming self-advocates, and educate families with information on many areas of need from insurance, to provider access, community resources, and navigating health care systems.

CCSHCN attendance and participation at Regional Interagency Transition Team meetings have increased staff knowledge of services available for families. CCSHCN staff also participated in a multitude of outreach activities designed to strengthen the agency's relationship with community partners. These activities included school open houses, local health fairs, workshops presented by Prevent Child Abuse Kentucky, public health nurse training, scoliosis screenings in schools, hearing screenings in schools, fluoride varnish treatment programs, and the multiple vitamin/folic acid distribution program.

CCSHCN Nurse Consultant Inspectors (NCI) participated in a 'train-the-trainer' workshop entitled "A Nurses Guide: Working with the Medically Fragile Resource Home in Kentucky." The NCIs subsequently trained other CCSHCN staff on working with the medically fragile population, as well as understanding our partnership with the Department for Community Based Services (DCBS).

An advisory board for the Medical Home for Coordinated Pediatrics was established and includes foster care social workers from the DCBS. The CCSHCN continued to follow the guidance of the Medical Advisory Board and advisory boards for the Hemophilia program and Early Hearing Detection and Intervention program.

Information about CCSHCN services, as well as other state and federal family assistance resources was available on the agency website. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Families with children who require services from multiple specialists were scheduled to see multiple providers in one clinic visit.	X			
2. The CCSHCN employs two parent consultants who educate families in the navigation of community-based service systems.		X	X	
3. CCSHCN staff partner with and participate on advisory boards and councils which are community-based, i.e. Regional Interagency Transition Team and First Steps.		X	X	
4. CCSHCN staff attend community organized events statewide to promote and distribute information about the agency and its services.		X	X	
5. The CCSHCN offers materials in other languages, as well as seeks out resources for families that are culturally competent.		X	X	X
6. The CCSHCN utilizes a voice mail system with a separate voice mailbox with information in Spanish. Staff with the Cabinet for Health and Family Services translate the messages for staff.		X	X	
7. The CCSHCN provides consultative nursing services to the Department for Community Based Services social work staff for children in the foster care system.		X		
8.				
9.				
10.				

b. Current Activities

/2010/ CCSHCN Parent Consultants will continue to work with families so that they can better understand the system of social and health care in which they participate and become advocates for the services their family needs. In 2009, the CCSHCN is receiving a grant award from HRSA to initiate Family to Family (F2F) partnerships statewide. F2F will create opportunities for family to family mentoring, so families can increase their ability to access services and supports, be more self-assured as they participate in decision-making and make informed choices about health care that promote good treatment decisions, cost effectiveness and improve health outcomes for their children throughout their lives. F2F will also improve access to accurate, up to date information regarding health care needs and resources available for CSHCN.

The CCSHCN strives to maintain resources that provide information on various topics in multiple languages for families who are limited in English proficiency. As well, every effort is made to provide materials at or below a third grade literacy level.

Questions pertaining to community-based service systems are included in the KY Children with Special Health Care Needs Five Year Needs Assessment survey. //2010//

c. Plan for the Coming Year

/2010/ Families with children who require services from a multi-disciplinary team during a clinic visit will continue to be scheduled to see multiple specialists in one visit.

CCSHCN staff will continue to communicate with families to determine areas of disorganization in community-based systems; and assist families with the navigation of those systems.

The CCSHCN will review frequently requested informational topics to consider producing one page informational summaries and resources.

The CCSHCN will continue to participate in Regional Interagency Transition Team meetings. Staff will continue to develop partnerships with community leaders to help streamline the process of accessing community resources. //2010//

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	50	51	52	53	30
Annual Indicator	13.6	9.6	9.7	55.4	52.1
Numerator	1250	821	859	897	790
Denominator	9214	8543	8862	1618	1517
Data Source					CCSHCN Database (FY 08)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	53	54	54	55	55

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN database for FY 2007-2008. Age group queried for this PM has been changed to 14-18. The data set queried for the numerator pertains to transition information that the CCSHCN primarily obtains beginning at the age of 14. The denominator data set has also been changed to the age group of 14-18. This will provide a better representation of the age group which is targeted for transition services for adulthood.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

/2010/ The CCSHCN continued to partner with many organizations to improve the transition process. Families were given information about trainings and services available to them to learn about the transition process.

The CCSHCN is the state Title V partner with the MCHB funded National Healthy and Ready to Work Center.

The CCSHCN is still actively involved in the KY Interagency Transition Council for Persons with Disabilities and the 11 Regional Interagency Transition Teams (RITT). RITT activities include participating in transition/family exhibit information fairs, job/transition fairs and Disability Mentoring Day activities that place CYSHCN in one-on-one contact with employers.

The CCSHCN Transition Administrator is the Chair of the Statewide Council for Vocational Rehabilitation, and on the Board for Directors for the Center for Accessible Living.

The Youth Advisory Council (YAC) Chair and the CCSHCN Transition Administrator presented at the Statewide Council for Vocational Rehabilitation Spring meeting in Lexington. Other members of the YAC presented at the annual KY Vocational Rehabilitation Association Training conference in Louisville. Members of the YAC also participated in the development of a Public Service Announcement, produced by the Kentucky Interagency Transition Council for Persons with Disabilities, regarding transition and how to obtain information on transition services (website is www.transitiononestop.org).

Transition assessments were completed on CYSHCN patients at the CCSHCN over age 2, and documented in the electronic data system. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCSHCN staff utilize and update Transition Checklist. Information is documented in electronic data system. Items on checklist identify readiness to transition to adult life, including ability to perform activities of daily living, insurance coverag		X		X
2. The CCSHCN provides training and planning resources to members of the Youth Advisory Council; and solicits ideas for training needs.		X		X
3. The CCSHCN provides training and planning resources to members of the Parent Advisory Council; and solicits ideas for training needs.		X		X
4. The CCSHCN partners with other federal and state organizations which educate and support youth and adults in the transition process, such as the Healthy and Ready to Work program, Vocational Rehabilitation and Center for Accessible Living.		X	X	
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

/2010/ Information and questions regarding transition issues is part of the CSHCN Five Year Needs Assessment survey.

Transition services are addressed through one-on-one discussions with families enrolled in CCSHCN programs, and by collaborating with community partners and encouraging participation from all members of the special needs community. Families are interviewed and participate in an intake/eligibility process, then complete a Transition Checklist. The Checklist is comprised of 2 sections, health skills and independence/school/work. Designated staff are required to document whether skills have been accomplished, are in progress, or part of future expectations. Age appropriate information is provided to families about their child's development.

The CCSHCN continues to collaborate with families, partnering agencies, the Parent Advisory Council and Youth Advisory Council to determine process needs. //2010//

c. Plan for the Coming Year

/2010/ CCSHCN staff will work with the Advisory Board, Youth Advisory Council and Parent Advisory Council to address needs identified in the Five Year Needs Assessment.

CCSHCN staff will continue to utilize the Transition Checklist and document transition information in the electronic data system.

CCSHCN staff will continue to work with families, schools and other community partners to identify the gaps in transition services and address transition needs. Families will be educated on the expectations they should have for their child's transition into adult life. As well, skills checklists will be reviewed with families.

The CCSHCN plans to increase the number of youth who present medical cards and will discuss appropriate age levels at which to begin to have CYSHCN co-sign for medical treatment.

The CCSHCN will develop a KY Family to Family (F2F) Health Information Center through grant funding from HRSA. The KY F2F Health Information Center will build on an existing network of family advocates in partnership with a statewide network of Title V CYSHCN to promote better access to health care for CYSHCN, including transition services. //2010//

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	77	82	92	92	86
Annual Indicator	79.1	79.7	84	80.9	80.9
Numerator					

Denominator					
Data Source					CDC's NIP Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	88	88	90	90

Notes - 2008
Numerator and denominator data are not available. Data is from the CDC NIP survey. Data reflects year 2007, the 2008 data will not be available until sometime next year.

Notes - 2007
Numerator and denominator data are not available. Data is from the CDC NIP survey. Data reflects year 2006, the 2007 data will not be available until sometime next year.

Notes - 2006
Numerator and denominator data are not available. Data is from the CDC NIP survey.

a. Last Year's Accomplishments
/2010/ Within the Department for Public Health, the Division of Epidemiology and Health Planning is the lead division for the immunization program. Programs operated by the Title V agency and LHDs routinely assess immunization status. Immunizations are provided through the LHDs, private physicians, federally qualified health centers, and school based health centers.

A child's immunization status is assessed and referrals are made within the health, education and social service delivery systems. Specific programs within the Division of Maternal and Child Health that effect this measure within preventive and primary services for children include the following: Regional Pediatrics Program; Child and Youth Project; Well Child Program; Health Access, Nurturing Development Services (HANDS); WIC; and Healthy Lifestyle Education.

Data for this measure is provided by the Kentucky Immunization Program (KIP) program and by the CDC's National Immunization Survey (NIS). The NIS has been conducted annually since 1994 by the National Immunization Program and is used to obtain national, state, and selected urban area estimates of vaccination coverage rates for US children between the ages of 19 to 35 months. The NIS is a random digit dialing telephone survey of households with age-eligible children followed by a mail survey of the children's vaccination providers to validate immunization information. National vaccination rates are based on the entire survey sample of more than 30,000 completed interviews. The sample size for each state is considerably smaller and for this reason has a much larger confidence interval.

Annual Activities
The Department for Public Health supplies vaccines to local health departments and private providers enrolled in the Vaccines for Children (VFC) Program. The VFC Program is a national program that uses federal funds to provide vaccines free of charge to Medicaid eligible, uninsured, American Indian or Alaska Native and underinsured children. In addition Kentucky began providing vaccines to underinsured children through the Kids

Now tobacco settlement initiative in August of 2000.

KIP participates in the national AFIX program to assist in improving immunization coverage levels among VFC providers in Kentucky. KIP field staff are responsible for conducting annual site visits to VFC providers to assess immunization coverage levels of children 24-35 months of age and provide ongoing education regarding methods to increase immunization coverage levels. Methods include reminder and recall systems, immunizing children during sick visits as well as well-child visits, and providing education to parents on the importance of immunizations and the lack of connection between autism and immunizations. KIP field staff monitor compliance with vaccine storage and handling requirements to minimize the loss of vaccine.

KIP conducts an annual school survey to assess the coverage levels of children enrolled in daycares, head start programs, preschools, kindergartens and sixth grade. KIP field staff audit a sample of these schools to ensure census survey data is accurate and provide assistance to schools in assessing children's compliance with immunization requirements. The parents of these children are contacted and informed of their child's need for immunizations.

Last Year's Accomplishments (2008)

As part of the VFC program, transaction data for 2008 indicates that KIP distributed 654,492 vaccine doses to public providers and 389,526 vaccine doses to private providers, for a total of 1,044,018 doses, for administration to Kentucky children aged 0 to 18 years of age. Vaccines distributed by KIP cover Diphtheria, Tetanus, Haemophilus Influenzae B, Hepatitis A, Hepatitis B, HPV, Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rotavirus, Rubella and Varicella. Transaction data cannot be extrapolated by age.

The most current NIS data (for 2008) indicates a coverage rate of 76.8% (CI 6.3) for the 4:3:1:3:3 immunization series of Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus Influenzae B and Hepatitis B for children 19 to 35 months of age. NIS data reflects a sample of children in Kentucky, regardless of their participation in the VFC program, and is a more accurate reflection of coverage than KIP could provide. However, NIS data reflects immunization practices from September 2006 to January 2008 and does not provide coverage data for all immunizations provided by KIP. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Purchase of vaccines to cover the underinsured, non-Medicaid and non-KCHIP children	X		X	
2. continued financial support for immunizations from the KIDS NOW Early Childhood Authority			X	X
3. Continued program activity by the Division of Epidemiology and Health Planning Immunization Program			X	X
4. Partnerships with the Department for Education and Head Start to include immunization as a requirement for enrollment				X
5. Increased outreach by local health departments for EPSDT / Well Child Preventive health visits	X		X	X
6.				
7.				

8.				
9.				
10.				

b. Current Activities

/2010/ In addition to the annual activities, an additional $2,255,364 has been added to the State FY 08-09 biennial budget for vaccination of underinsured children. The cost of vaccines has risen approximately 14% from 2008 to 2009. This variable reiterates the fact that the cost to vaccinate a child increases each year.

KIP is currently working on developing a secure and confidential web-based Immunization Registry through a contract with Custom Data Processing (CDP). The Immunization Registry will help to ensure that all persons within the Commonwealth of Kentucky are protected against vaccine-preventable disease. The registry will be used to identify pockets of need, consolidate records for individuals who do not have a medical home or who move, minimize vaccine administration errors and help to measure the effectiveness immunization campaigns. The Immunization Registry is projected to go online October 2009.

The Kentucky Immunization Registry Workgroup, which is composed of representatives from local health departments, the Deputy Commissioner for Public Health, Epidemiology and Health Planning Division staff and KIP staff, meets twice a month to review changes and additions to the immunization registry. //2010//

c. Plan for the Coming Year

/2010/ In addition to annual VFC/AFIX activities and school surveys in 2010, KIP will begin an Adolescent AFIX program to improve the immunization coverage level of adolescents who are patients of VFC providers in Kentucky. Furthermore, the Immunization Registry is projected to be fully operational in all local health departments and some selected private providers by the end of 2010. //2010//

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	29	21	23	23	23
Annual Indicator	23.7	23.9	25.2	25.0	24.2
Numerator	1928	1994	2141	2139	2067
Denominator	81291	83328	84817	85420	85420
Data Source					KY live birth certificate files and U.S. Census Bu
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than					

5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	23	23	22	22	21

Notes - 2008
2008 data is preliminary and numbers could change. The 2008 Census population estimates are not currently available therefore the denominator reflects 2007 census population estimates.

Notes - 2007
2007 data is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change. Teen birth rates have been steadily declining in KY as well as the nation over the last few years. Teen birth rates increased by 2.7% in 2006 in Kentucky as well as the nation. This was the first increase in 15 years nationally.

Future Objectives were reviewed but no changes were made at this time because the 2006 data is preliminary and numbers could change.

a. Last Year's Accomplishments
/2010/ For 2007 the teen birth rate for females aged 15-17 increased from 25.2 per 1,000 in 2006 to 25 per 1,000. The Kentucky birth rate is consistent with the upward trend in national birth rates. The national preliminary birth rates for girls aged 15-17 in 2006 was 22 per 1,000, up 3% from a record low of 21.4% in 2005 according to the National Center for Health Statistics.

A full array of reproductive healthcare services for individuals of all ages is available through federal Title X funds allocated to local health departments. Services include client education,, counseling, history, physical assessment and laboratory testing, fertility regulation, infertility services, pregnancy diagnosis and counseling, adolescent services, gynecologist services and sexually transmitted diseases.

108,430 women, men and adolescents were served through the Title X program in calendar year 2008. Of those served, 17,719 were between the ages 15-19. These services provide primary and preventive health intervention services for adolescents. The services for adolescents that affect this measure include: the School Health and Adolescent Preventive Health Services, Family Planning for Teens, Teen Pregnancy Prevention, Abstinence and Healthy Lifestyle Education.

The Kentucky Family Planning Title X Program has several special initiatives targeted to service disparate populations. Two Hispanic clinics target low income under insured Hispanic clients. Brighton Center Youth Development Program in Newport, Kentucky teaches positive youth development skills and refusal skills towards risk taking behaviors. Family Participation Workshops encourage family participation in the decision of minors seeking family planning services. The Pike County Male Special Initiative Project services a local health department clinic, a college based clinic, and an in-school program for middle school males who are taught goal setting and self esteem skills. Two initiatives focus on teen pregnancy prevention they are the Teen Pregnancy Prevention Intervention Program and the University of Kentucky Young Parents Program (YPP). Both agencies provide intensive counseling to teens to prevent teen pregnancies and repeat teen births and also comprehensive adolescent preventive health care services. YPP is unique because it places emphasis on medical, nursing, and nutritional care for both mother and child, education toward better parenting, career and educational counseling, psychosocial support of family unit; and family planning services.

Kentucky received $817,297 in FY 2008 in Federal Title V, Section 510 B grant funds for the Abstinence Education Program. In FY 2008, 95 % of the funding was awarded by the DPH to 14 local health departments statewide reaching rural and urban areas. In FY 2007, 37,806 10-19 year olds received abstinence-until-marriage education services and approximately 28,000 adolescents received the services in FY 2008. The main goal of Kentucky's Abstinence Education Program is to reduce teen out-of-wedlock birth rates and pregnancies. These funded agencies provided abstinence-until-marriage education services using evidence based behavior modification strategies to provide a clear and consistent abstinence-until-marriage message, without contraception and condom use, early and reinforced the message by continuing abstinence interventions throughout the adolescent years. Two major focuses of Kentucky's Abstinence Education Program Grant are positive youth development, through teaching values and practical skills to abstain from sexual activity, and the development of strong partnerships among non-profit public and private community agencies, faith-based organizations, parents, and schools. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued strategic planning with partners			X	X
2. Continued training opportunities through the Title X Family Planning funding support		X	X	X
3. Partnership coordination with the Coordinated School Health program to encourage schools in positive youth development			X	X
4. University of Kentucky Young Parents Program, Pike County Male Special Initiative Project and Teen Pregnancy Prevention Intervention Program	X	X	X	
5. Partnership with the Kentucky Teen Pregnancy Coalition			X	X
6. Strategic Planning with partners from AMCHP, HIV, and STI Prevention and Adolescent Health			X	X
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ Kentucky received $5,888,560 in federal Title X funding. Kentucky funds 169 Title X clinics, the majority of funding being allocated to local health departments to assure access to family planning services throughout Kentucky's 120 counties. Local health departments may opt out to use a portion of their federal Title V Block Grant allocation to support family planning program efforts in their community. All Title X delegate agencies must have a sliding fee scale based upon federal poverty guidelines and must offer all methods of FDA approved contraceptives, including emergency contraceptive pills. Title X funding does not fund abortions.

Family Planning initiatives include two Hispanic clinics; Teen Pregnancy Prevention Intervention Program, Young Parents Program; Brighton Center Youth Development Program; Family Participation Workshops; and the Pike County Male Initiative Project.

Kentucky received $187,297 in federal funding allocated to 14 local health departments. Programs are designed to improved adolescent health outcomes and enhance the positive youth development of Kentucky's youth through school programs, parent education workshops, pubic awareness events, adult and peer mentoring programs, and community

coalitions/partnerships. School and community-based abstinence education curriculum are specifically designed for adolescents aged 10-19. Programs are taught by peer educators who reinforce the message through positive peer pressure. //2010//

c. Plan for the Coming Year

/2010/ 2010 Goals include: To assure access to comprehensive quality family planning services to individuals, families, and communities through outreach to hard-to-reach and/or disparate populations and partnering with community-based health and social service providers; to provide comprehensive reproductive preventive services to enhance the health of Kentucky women and families as demonstrated in improved prematurity rates, STD prevalence, cancer screening and decreased teen pregnancy and birth rates; and to assist women, teens, and men to prevent unintended pregnancy and plan healthy pregnancies.

Women of childbearing age and men will have the information and means to protect themselves from sexually transmitted diseases and STDs will be reduced in this population.

To help meet these goals, the program must continue to market services through community partnership committees and community plans; prepare or recruit additional provides; continue outreach to hard-to-reach and vulnerable populations in non-traditional service sites already established; and expand non-traditional sites to new areas. Collaborations with community/school/health department teen pregnancy prevention initiatives in all 120 counties, while also promoting and conducting Parent Workshops through local health clinic's programs, will assist in promoting teens delaying sexual involvement and ultimately decrease the teen pregnancy rate.

Kentucky's Abstinence Education Program Goals for FY 2010:

Goals include: At least 51% of the youth aged 10-19 who receive abstinence-until-marriage education demonstrate both an understanding of the benefits of delaying sexual activity until marriage and intention to delay sexual activity until marriage; and approximately 2,000 youth aged 10-19 will receive 8 hours of abstinence-until-marriage education. //2010//

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	35	33	33	30	31
Annual Indicator	29.0	29.0	29.0	29.0	23.9
Numerator	15222	15222	15222	15222	18790
Denominator	52489	52489	52489	52489	78505
Data Source					U.K. denatl sealant program data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	31	31	32	32	32

Notes - 2008
The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2007
The survey was last conducted in 2004. The Oral Health program anticpates conducting the survey next calendar year and will have updated data the following year.

Notes - 2006
The survey was last conducted in 2004. The Oral Health program anticpates conducting the survey next calendar year and will have updated data the following year.

a. Last Year's Accomplishments
/2010/ The dental sealant program for school-aged children also began in July 2003. Last year, the Kentucky Sealant Program funded 15 health departments at a total of $180,000 through general state funds. In collaboration with local dental hygienists and dentists as well as community schools, local health departments were provided with funding to contract with dental professionals to place sealants in children that had need to do so. Most programs focused on sealant services in second, third and six graders throughout the Commonwealth. Parents were informed on the program through informed consent signature forms. In FY07-08, approximately 12,000 sealants were provided to children through this program. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provides grant to selected local health departments to fund local level dental provider partnerships for sealants.	X			
2. Ongoing support of the Kentucky Children's Oral Health Surveillance System, tracking oral disease and sealant use throughout the Commonwealth.			X	X
3. Continued oral health education at the local level to families, health providers, including nurses and physicians, and the community			X	
4. KIDS Smile Fluoride Varnish Program through local health departments, which includes the application of fluoride varnish and good oral health care education to the parents and family.	X		X	
5. Continued partnership with the University of Kentucky College of Dentistry and their sealant outreach program, reaching children statewide and especially in rural, underserved areas	X	X	X	
6. Ongoing strategic planning for children's oral health care in Kentucky			X	X
7. Continued collaboration with the UK Center for Rural Health with their growing outreach to underserved populations in rural Kentucky			X	X
8.				

9.				
10.				

b. Current Activities

/2010/ The Kentucky Oral Health Program funds sealant activities in 15 health departments. Local health departments and their community partners continue to move the identified child to the contracted dental office for sealant services.

Health departments are receiving funding for the placements of sealants, however accountability and reporting of activities is unpredictable and inconsistent. The program is currently working with the University of Kentucky and health departments to research, develop and implement a uniform sealant reporting program. Goals include capturing appropriate services for this funding stream, and should be finalized in the fall of 2009, with testing then implementation by January 2010.

The Kentucky Oral Health Program (KOHP) is in year 2 of the four-year Targeted MCH Oral Health Service Systems (TOHSS) Grant receiving funds to advance the program toward sustainability providing a statewide approach to preventing oral disease. TOHSS purpose is supporting the expansion of preventive and restorative oral health services for Medicaid and State Children's Health Insurance Programs (SCHIP) eligible children and other underserved children and their families. Strategies will address increasing the number of children completing restorative treatment. Developing community oral health coalitions will provide solutions to barriers to the lack of dental providers accepting Medicaid/KCHIP eligible children and benefits of preventive care for children. //2010//

c. Plan for the Coming Year

/2010/ Because of the severe need of active disease in children's mouths, many health departments are using some of the sealant allocations for restorative and extraction services. The Kentucky Oral Health program is planning to reevaluate their sealant program including its structure, its funding, it reporting and its effectiveness. The sealant program has changed shape since its inception and it is clear to the dental director that it needs to be solidified as what it should be: a sealant program, with the intent that it should be school based in its service site. The challenge comes in Kentucky with the shortage of dentists, layered with the shortage of dentists that are willing to provide preventive services in the school based setting. Because of the intermittent use of these funds for disease control in this population, it demonstrates the need for a separate funding stream for this along with the sealant funding allocations to local health departments.

In the past, the Kentucky Sealant Program provided allocations to the local health departments to pay for sealant application through contractual agreements with local dentists. Referrals came from the clinic nurses, as well as the school-based health department nurses. No particular subgroup of the pediatric population was targeted, nor excluded. The points made in the CDC's review of the sealant program are valid and has changed our program to include special outreach to higher-risk children such as special education students and children with special health care needs. It presents an opportunity for the Kentucky Oral Health Program to build on our relationship with the Commission for Children with Special Health Care Needs to target their higher-risk clients/patients.

The Kentucky Oral Health Program will continue its long standing contractual relationship with the University of Kentucky College of Dentistry to underwrite their efforts in outreach services to Kentucky's underserved pediatric population. The fund allows the University to expand its services geographically in the upcoming year. While continuing their fixed clinic and mobile dental outreach in southeastern Kentucky, they are implementing a

significant expansion of their program in the western part of the state. Their mobile dental services for children will be approximately doubled as well as opening a fixed clinic in Madisonville that will serve this population for preventive as well as restorative services. //2010//

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5.9	5.8	4.6	4.5	3
Annual Indicator	6.1	5.0	4.6	2.5	2.7
Numerator	50	41	38	21	22
Denominator	826377	823524	828830	828157	828157
Data Source					KY vital stats death certificate files & U.S. cens
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.5	2.5	2	2	2

Notes - 2008
2008 data is preliminary and numbers could change. 2008 census population estimates are not currently available therefore, 2007 population estimates were used for the denominator.

Notes - 2007
2007 data is preliminary and numbers could change.
Because 2007 data is preliminary, future objectives for National Performance Measure #10 will not be revised at this time.

Notes - 2006
2006 data is preliminary and numbers could change. A slight decline was observed in this indicator from 2005-2006. KY was successful in passing a Primary Seat Belt Law and the Graduated Driver's License Program during our last legislative session. It is hopeful that with continued prevention and education efforts along with the two new laws, that this indicator will continue to decline.

Future objectives were reviewed but no changes were made at this time because the 2006 data is preliminary and numbers could change.

a. Last Year's Accomplishments
/2010/ The Kentucky General Assembly passed the Booster Bill in July 2008. Beginning July 1, 2008 law enforcement in the state of Kentucky began issuing warnings to persons

caught not properly restraining their children. Warnings will no longer be issued and the crime will be punishable by a monetary fine beginning July 1, 2009. A Booster Seat Coalition was formed and its members, including the CFR program coordinator, have been actively promoting the new bill. Trainings were conducted to ensure that every Kentucky State Police post had at least one certified child passenger safety technician. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with other CDC grants including the Core Injury Prevention grant and the Kentucky Violent Death Reporting Systems grant, both administered by DPH and include multiple partners and collaborations.			X	X
2. Enhancement of the Child Fatality Review process to increase the development and participation of local CFR teams			X	X
3. Injury prevention training included in the HANDS HOme Visitation curriculum		X	X	X
4. Collaboration with the Kentucky Injury Prevention Research Center at the University of Kentucky		X	X	X
5. Participate inn the Governor's Drive Smart Team that includes safety seat checkups and other safe driving initiatives		X	X	X
6. Collaboration with Coordinated School Health to provide safety information brochures		X	X	X
7. Continuation of the Kentucky Safe Kids Coalition adn local Safe Kids chapters		X	X	X
8. Publication of the Child Fatality Review annual report		X	X	X
9. Ongoing strategic planning for children's safety and injury prevention in Kentucky			X	X
10. Passage of the Booster Bill into law July 2008 enforcing proper restraint of children in motor vehicles and punishable as a crime with a monetary fine		X	X	X

b. Current Activities

/2010/ The CFR program continues to be a vital part of the Maternal and Child Health Division.

The annual report reflects the patterns, trends, and risk factors that are seen through data collection. Local CFR teams prove invaluable and continue to contribute to the success of the program at the state level. With most counties already participating and training in the works for the formation of more local teams, the future of Kentucky's CFR program looks bright.

Kentucky has submitted a grant application to implement a statewide registry of all sudden unexplained infant deaths (SUID) occurring in Kentucky. The goal is to increase knowledge about the prevalence, causes and potential preventive strategies related to SUID in Kentucky. This will be an on-going activity, covering the next few years. The CFR program coordinator will be working with several other individuals on the project upon notification from the CDC that the application is accepted.

Education of the new Booster Seat Law continues to be a priority at every level. Law enforcement is being trained on the new requirements for our children under age 7 and between 40 and 50 inches. Health departments are being informed of the new changes so that they may help educate the public. Education to the public is a task that will be on-going through many different avenues. //2010//

c. Plan for the Coming Year

/2010/ Many of this year's activities will be ongoing throughout the next year. Kentucky will continue to increase their number of local CFR teams. To form these teams and keep them functioning properly we offer continued technical assistance and training from the state coordinator.

The Director of Maternal and Child Health, the state CFR program coordinator and other important party members recently held a strategic planning meeting to discuss the CFR program, its process, and proposed changes to the current screening process for child deaths in the state. The goal is to have every child death case reviewed. Every case will either be reviewed at the local level or by the state team. Follow-up will be conducted at the state level with the local teams to ensure they are reviewing their appropriate cases. This screening process at the state level will also ensure any pertinent information for that case will get to the local level if it is not reviewed by the state team. Program staff will encourage the local teams and the state team to work toward preventive efforts from their reviews. //2010//

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			25	26	28
Annual Indicator		25.3	27.5	23.2	23.2
Numerator		13915	3980	3416	3416
Denominator		55000	14465	14725	14725
Data Source					Pediatric Nutrition Surveillance Survey for KY
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	29	30	30	31

Notes - 2008
2008 data is not currently available data shown reflects year 2007.

The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2007

Data reflects 2006 data. The 2007 data is not yet available.

Notes - 2006
Data for 2005 was incorrectly calculated and should be 7080/27987.

a. Last Year's Accomplishments
/2010/ During 2008 breastfeeding initiation and duration rates were increased through education, promotion and support. Nine breastfeeding coalitions met and provided continuing education, support and leadership for health professionals. World Breastfeeding Week was held in August with many activities across the state for mothers and health professionals. The funding was continued for the ten Breastfeeding Regional Coordinators. Training and technical assistance was provided to the Peer Counselor sites and the total number of sites was increased from 9 to 13. Education materials continue to be translated into Spanish. The breastfeeding bill, Senate Bill 106 was promoted in an effort to increase awareness about breastfeeding protection in public places. The breastfeeding bill SB111 was also discussed to provide awareness for breastfeeding mothers who can be excused from jury duty. The Clinical Nutrition Section continues to collaborate with the CDC Nutrition, Physical Activity and Obesity grant, University of Kentucky and other public and private partners. One of the staff became an IBCLC. The staff member was the first person admitted into University of KY Breastfeeding Internship Program. An intensive training on breastfeeding was provided for 60 public and private health professionals to support development of IBCLC's. The Baby Friendly Hospital Initiative continues to be promoted. The Section celebrated Earth Day focus on breastfeeding across the state. The Section worked with USDA to host the NWA Breastfeeding and Nutrition Conference held in KY during September 2008. Training was provided for worksites to establish a breastfeeding room. The Section worked on new ideas to promote breastfeeding in Kentucky. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Training and support of WIC Breastfeeding grantees for breastfeeding promotion in local communities	X		X	X
2. Continued Breastfeeding Coalition building			X	X
3. Training provided to local hospitals and community supporters / partners			X	X
4. Pormotion and training of the health benefits of breastfeeding in the HANDS Home Visitation curriculum	X		X	X
5. Promoted the breastfeeding bill, Senate Bill 106 in an effort to increase awareness about breastfeeding protection in public places		X	X	X
6. Participation in world and national breastfeeding promotion campaigns			X	X
7. Continued collaboration with Fit KY, Regional Breastfeeding Coordinators and Shape the Future Steering Committee			X	X
8. Collaboration with CDC Nutrition, Physical Activity and Obesity Grant			X	X
9. Worked with USDA to host the NWA Breastfeeding and Nutrition Conference held in Kentucky in September 2008			X	X
10.				

b. Current Activities
/2010/ Promotion and support of increased breastfeeding initiation and duration rates through continued education are continuing. Efforts continue to increase participation in

the state breastfeeding coalition. Kentucky will participate in World Breastfeeding Week during August 2009. Funding continues for the 10 Breastfeeding Regional Coordinators. Breastfeeding continuing education programs will be offered in the state. Section staff are working to increase the number of hospitals trained on breastfeeding promotion and support. WIC participants receive hospital grade and single user breast pumps to support duration. The Baby Friendly Hospital Initiative is being supported across the state. New education modules are being made available to local agency staff on breastfeeding promotion, breastfeeding education and three-step counseling. Staff are promoting and implementing the Breastfeeding Worksite Toolkit. Participation in health fairs continue with an effort to promote and support breastfeeding and nutrition. The Breastfeeding Peer Counselor Program is maintained in 13 sites. Efforts will be focused on training for worksites to establish a breastfeeding room. There is ongoing collaboration with the CDC Nutrition, Physical Activity and Obesity Program, University of Kentucky and other public and private partners as staff continue to promote, support and provide education about the Kentucky breastfeeding legislation. //2010//

c. Plan for the Coming Year

/2010/ Department staff will plan a Breastfeeding Summit for the fall of 2010. Staff will distribute a Breastfeeding Needs Assessment and analyze information. The breastfeeding section will continue to work to increase breastfeeding initiation and duration rates through continued education, promotion and support. Efforts will continue to increase participation in the statewide breastfeeding coalition. The World Breastfeeding Week will be celebrated in Kentucky during August of 2010. Funding will be maintained and continued for the 10 Breastfeeding Regional Coordinators. Intensive breastfeeding training will be offered in the state to increase the number of IBCLC's. Staff will continue to provide breastfeeding and nutrition continuing education programs. Efforts will be focused on increasing the number of hospitals trained on breastfeeding promotion and support. Breast pumps (hospital grade and single user) will continue to be provided to WIC mothers. The Baby Friendly Hospital Initiative will continue to be supported and promoted in the state. Online education modules on breastfeeding and nutrition will be developed for local health department staff training. The Breastfeeding Worksite Toolkit will be promoted throughout the state. The staff will continue to promote and support breastfeeding and nutrition through participation in health fairs and conferences with displays and education materials. The Breastfeeding Peer Counselor Program will be continued in 13 sites will be increased to other sites with additional funding. Continued training will be provided for worksites to establish a breastfeeding room. Collaboration will continue with the CDC Nutrition, Physical Activity and Obesity staff, University of Kentucky and other public and private partners. Efforts will continue to focus on breastfeeding legislation. Staff will continue to revise and develop breastfeeding and nutrition education materials for local agencies. Efforts will focus on the development of new materials for Breastfeeding Peer Counselor Program. //2010//

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	99	99	99	99	99
Annual Indicator	99.4	99.8	99.8	99.0	96.8
Numerator	51849	51837	51837	57619	54805
Denominator	52172	51932	51932	58184	56635
Data Source					EHDI Program (CY

					08)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99	99	99	99	99

Notes - 2008
The data for this PM is provided by the KY Early Hearing Detection and Intervention program.

a. Last Year's Accomplishments
/2010/ In 2008 the EHDI program provided on site support to all 56 birthing hospitals in the Commonwealth of Kentucky including program evaluation, technical assistance and staff training. Two grants were awarded during 2008 from HRSA/MCH and CDC both focusing on reducing loss to follow-up. As a part of the HRSA grant a loss to follow-up coordinator was hired to track all follow-up appointments made by 9 pilot hospitals prior to the newborn's discharge from the hospital. Between her hire date in August and the end of 2008, she had tracked 98% of the appointments with outcomes entered in the EHDI database. Additionally, with the CDC grant, the Cabinet for Health and Family Services Office of Technology KYCHILD team and the CCSHCN EHDI team combined efforts to move forward to enhance the capabilities of KYCHILD so that audiologists could report diagnostic results electronically. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The EHDI program provides on site support to all KY birthing hospitals.	X			
2. KY birthing hospitals screen all newborn hearing prior to hospital discharge.	X		X	
3. Results from hospital screenings are submitted electronically to the EHDI program. Information is maintained in the CCSHCN electronic data system.				X
4. Information is mailed to families of children who have a newborn hearing screen report indicating a risk for hearing loss. The information provides information about the risk and diagnostic audiological follow-up resources.		X	X	
5. The EHDI program provides follow-up to families who are not documented as having received diagnostic audioligcal testing.	X	X	X	X
6. The EHDI program hired a coordinator to provide oversight to the loss to follow-up initiative.	X	X	X	X
7. The EHDI program received two grants from HRSA/MCHB and the CDC to be used in reducing the loss to follow-up rate.			X	X
8. The EHDI program partners with the Office of Technology to coordinate an electronic system of information with hospitals and audiologists.			X	X
9. The EHDI program provides outreach and training to stakeholders.	X		X	X
10. Information about the EHDI program is available on the	X	X	X	X

CCSHCN website (in English and Spanish).				

b. Current Activities

/2010/ The EHDI program merged with CCSHCN's Audiology Branch in January 2009. Staff audiologists have been trained to support the hospital Universal Newborn Hearing Screening programs in their areas. As part of this smaller community approach, the audiologists meet with UNHS hospital staff to assess the need for equipment upgrades. The KYCHILD expansion for follow up advanced with training of the trainers set in June. CCSHCN audiologists and EHDI staff will be trained to support audiologists in other settings throughout the state during June and July and will also serve as the pilot users of the application. A parallel process of writing regulations for HB 5, a bill for audiology reporting is in draft, and could be routed to Cabinet level review in June 2009. As a part of the State Plan developed at the EHDI National Conference, EHDI will be working with the Commission for Deaf and Hard of Hearing and Hands and Voices to facilitate some of their goals including Guide by Your Side. An EHDI Advisory Board meeting is planned for the summer to assess our progress. As a method for establishing and maintaining the highest standards for the Audiology-EHDI program, a tool has been developed for assessing performance of our audiologists based on the Best Practices model recommended by the American Speech-Language Hearing Association. This model of continuous quality monitoring involves self assessment, peer audit and administrator audit on an intentional timeline. //2010//

c. Plan for the Coming Year

/2010/ The year 2010 will mark full implementation of the KYCHILD Audiology electronic reporting and the "Approved Audiology Centers" list. With the availability of electronic submission and mandatory reporting the expectation is that in 2010 more infants identified with hearing loss prior to 3 months of age will be entered into the CCSHCN data system necessitating the need to provide intervention resources to families. Working with the Kentucky Commission for Deaf and Hard of Hearing who will provide a packet of information and resources for the CCSHCN EHDI program to send to all involved families. During this year expansion of UNHS hospitals participating in the HRSA/MCH grant is targeted so that the referral pathway from hospital screening to evaluation to reporting of data becomes refined in all areas of the Commonwealth of Kentucky. Additionally, the CCSHCN hopes to replace outdated/non-supported audiology diagnostic equipment in all CCSHCN offices so that our services to infants and children are not compromised by equipment error. //2010//

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	6	6	7.5	8.5	9
Annual Indicator	9	6.7	9.7	8	8
Numerator					
Denominator					
Data Source					U.S. Census Bureau Current Population Survey for 2
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	7.5	7.5	7.5	7

Notes - 2008
2008 data not available yet, so 2007 data is used for preliminary reporting. Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

Notes - 2007
2007 data not available yet, so 2006 data is used for preliminary reporting. Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

Notes - 2006
Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

a. Last Year's Accomplishments
/2010/ After a decline from 9.7% in 2006 to 8.0% in 2007, the percentage of Kentucky's children without health insurance from CY 2006 through 2007, remained unchanged at 8.0% in 2008. This is approximately the same percentage of children without health insurance in CY 2003.

Beginning in October 2008 and continuing through FY 09, the Department of Medicaid Services and the Department for Public Health sponsored Train the Trainer conferences including live and on demand web casts and on site trainings to encourage participation of statewide agencies and providers in identifying and enrolling eligible children in KCHIP.

The Governor's KCHIP enrollment initiative enlists a broad range of statewide agencies and providers to work together to increase enrollment of Kentucky's children in KCHIP. These partners include but are not limited to the Department for Medicaid Services, the Department for Public Health, the Department for Community Based Services, Family Resource and Youth Services Centers, Kentucky public schools, community providers, the United Way, Kentucky Youth Advocates, Foundation for a Health Kentucky, Kentucky Action for Healthy Kids, and, in 16 Kentucky counties, Passport Health Plan.

The Department for Public Health contracts with statewide health departments to contact families of eligible children by phone, in clinic or during home visits, and provide assistance with completing the KCHIP application through activities of HANDS and the EPSDT and KCHIP Outreach programs. Families who choose not to complete an application at the time of a visit or call are provided or mailed an application and encouraged to contact local health department, local Department for Community Based Services offices or, in counties with Passport Managed Care, Passport representatives to make appointments or obtain assistance to complete KCHIP applications. Families who contact the DPH administered KCHIP hotline are assisted with completing the KCHIP application or are provided an application and encouraged to contact local health department, DCBS or, in counties with Passport Managed Care, Passport representatives for assistance with completing KCHIP applications. KCHIP hotline health department staff provides families with current information about enrollment status and follow up.

Passport Health Plan has employed 8 enrollment specialists to work with families of eligible children in 16 Kentucky counties to assist them with completing KCHIP

applications. The Department for Medicaid Services is working with Fayette County Health Department and Louisville Jefferson Department for Public Health and Wellness to identify children statewide whose KCHIP enrollment has been discontinued and contact them to provide assistance and follow-up with enrollment procedures. Louisville Jefferson Department for Public Health and Wellness collaborates with Passport Health Plan representatives to help families of eligible children complete KCHIP applications and follow up on enrollment.

Applications are mailed or faxed to a central processing center, the Department for Medicaid Services or can be delivered to local Department for Community Based Services offices. Central processing center staff follow up to assure the applications are complete and to update enrollment status. In an effort to enroll more children and retain recipients, the Department for Medicaid Services and statewide Family Resource and Youth Services Centers and public schools are partnering to identify children in need of KCHIP and help families with enrollment processes.

The Governor's KCHIP enrollment initiative enlists a broad range of statewide agencies and providers to work together to increase enrollment of Kentucky's children in KCHIP. These partners include but are not limited to the Department for Medicaid Services, the Department for Public Health, the Department for Community Based Services, Family Resource and Youth Services Centers, Kentucky public schools, community providers, the United Way, Kentucky Youth Advocates, Foundation for a Health Kentucky, Kentucky Action for Healthy Kids, and, in 16 Kentucky counties, Passport Health Plan. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued support for Medicaid / KCHIP enrollment and services through local health departments and the Commission for Children with Special Health Care Needs			X	X
2. Collaboration with Medicaid to access needed data for MCH programs			X	X
3. Collaboration with Medicaid / KCHIP program initiatives			X	X
4. Collaboration with EPSDT Outreach through local health departments	X		X	
5. Collaboration with Local Health Department Well Child programs	X		X	
6. Preparation for availability and processing of Mail-In applications to increase enrollment in KCHIP program		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ In FY 09, the Department for Medicaid Services made administrative changes to decrease barriers for families to enroll their children in the Kentucky Children's Health Insurance Program (KCHIP). These changes include availability of Mail In applications, an extended grace period for replying to requests for more information to complete applications, and training and partnerships with statewide community providers and agencies to increase enrollment of children in KCHIP more than 35,000 children by June 2010. Through FY 09, local health departments in 120 counties worked with community agencies to improve partnerships with schools and providers, implemented outreach programs to increase community awareness of the need for children's preventive health

exams and contacted families to inform them of the value and necessity of EPSDT preventive exams.

Passport Health Plan has employed enrollment specialists to work with families of eligible children in Kentucky counties to assist with completing KCHIP applications. The Department for Medicaid Services is working with Fayette County Health Department and Louisville Jefferson Department for Public Health and Wellness to identify children statewide whose KCHIP enrollment has been discontinued and contact them to provide assistance and follow-up with enrollment procedures. Louisville Jefferson DPH with Passport Health Plan to help families of complete KCHIP applications and follow up on enrollment. //2010//

c. Plan for the Coming Year

/2010/ During FYs 2009-2010, health departments will partner with statewide and community providers and agencies to reduce the number of uninsured children by conducting outreach to families of children who are uninsured or underinsured and by assisting families to complete applications for KCHIP coverage.

DMS and DPH plan to update KCHIP application training in FY 10 and promote Train the Trainer activities in collaboration with statewide community partners.

Plans are being considered to include enhancing current health department EPSDT and KCHIP outreach activities to include follow-up of KCHIP enrollment processes and status. //2010//

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			32	34	16
Annual Indicator		35.3	17.9	32.0	32.0
Numerator		45948	9626	18277	18277
Denominator		130165	53777	57117	57117
Data Source					Pediatric Nutrition Surveillance Survey for KY
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	31	30	30	29	29

Notes - 2008

2008 data is not currently available and numbers reflect 2007 data. For data year 2006, children between 2 and 5 who were obese were not included in the numerator only those at risk for being

overweight were reported; therefore, the 2006 indicator appears lower than other years. For years 2007 and 2008 those children receiving WIC between the ages 2 and 5 at risk of overweight or obese were reported in the numerator.

Notes - 2007
Data is from the PedNESS survey.

Notes - 2006
Data is from 2006 PedNSS survey of WIC providers in Kentucky. Data for 2005 should be 18.2% (10,051/55227), but cannot be changed on the form. Data from 2006 is also from KY PedNSS.

a. Last Year's Accomplishments
/2010/ During 2008, the Section provided funding for a network of Registered Dietitians/Certified Nutritionists to provide Medical Nutrition Therapy in 110 of 120 counties. Funding was also provided for community and school nutrition activities in all 56 agencies. The staff provided wellness and nutrition activities for employees in the Cabinet. State and local staff provided nutrition information at the Kentucky State Fair and answered questions for attendees. During the year, 10 new/revised nutrition materials were printed for local health departments to use with clients. The staff completed the second year of nutrition monitoring for quality assurance in 20% of agencies. Staff were used as preceptors and provided internship experience for 4 nutrition students. The Section continued to provide leadership and education for participation in WIC Farmers' Market Nutrition Program. Staff is a liaison to the following committees/coalitions: Kentucky Action for Healthy Kids, Partnership for a Fit Kentucky, Kentucky Diabetes Network, Folic Acid/Prematurity Partnership, School Health Coalition, AHEC Health Careers Outreach and Kentucky Food Security Partnership. During 2008, the staff assisted in hosting the National WIC Association Nutrition and Breastfeeding Conference on September 23-25 in Louisville. Staff developed a new fruit and vegetable logo and provided training. As a part of efforts to implement VENA for USDA, staff conducted focus groups to evaluate new materials.

Kentucky's WIC Program is available in all 120 counties. The WIC Program provides counseling to all children and women concerning healthy foods and the importance of regular physical activity. The current caseload for WIC is approximately 135,000 participants. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Physical Activities promoted through local health departments	X		X	X
2. Nutritional counseling to families available through local health departments	X		X	X
3. Collaboration between local health departments and schools to promote physical activity and nutrition		X	X	X
4. Wellness and nutrition activities provided for Kentucky employees and nutrition information provided at the Kentucky State Fair	X	X	X	
5. HANDS Home Visitation services	X	X	X	X
6. Provided leadership and education for participation in WIC Farmer's Market Nutrition Program	X	X	X	X
7. Well Child and Adolescent Preventive Health and Nutrition servcies training for local healht department staff				X
8. Continued collaboration and strategic planning with multiple			X	X

partners				
9. Automated BMI and Growth Charts	X	X	X	X
10. Expanded WIC Program in all 120 counties, statewide, that provides counseling to all children and women on healthy foods and the importance of regular physical activity.	X	X	X	X

b. Current Activities

/2010/ VENA is being finalized and implemented as a part of a USDA initiative. The new WIC Food Packages were implemented which provide fresh fruits/vegetables and whole grains with a reduction in juice. Efforts continue to refine automated risk and growth charts to work with VENA. Funding continues for the local health department dietitian/nutritionist network. Nutrition and breastfeeding materials are being revised and updated and will be displayed at the State Fair. Quality assurance monitoring and technical assistance continues. Liaison relationships continue with Partnership for a Fit KY, Folic Acid and Prematurity Partnership, Arthritis Partnership, KY Diabetes Network, Kentuckiana Lactation Improvement Coalition, Western KY Breastfeeding Coalition, Coordinated School Health Coalition, AHEC and the KY Food Security Partnership. Nutrition is a focus in employee wellness and employee health fairs. Leadership, assistance in management, and conduct technical assistance and training for the WIC FMNP continue. Online education modules will be pilot tested for use to train local health department staff, as are new online modules with KCTCS for educating local staff on relevant WIC. Training and technical assistance for local agencies will continue to be a focus. The Section staff will continue to act as a preceptor site for nutrition interns. New breastfeeding and nutrition materials will be developed as needed. //2010//

c. Plan for the Coming Year

/2010/ For the future, the staff will continue to work on the web-based system for WIC and expand the system statewide. The WIC Farmers' Market Nutrition Program will be continued if USDA funding is continued and staff will provide training, technical assistance and monitoring. The quality assurance monitoring will continue to be provided by staff and training and technical assistance will occur as needed. Funding will continue for the dietitian/nutritionist network to provide Medical Nutrition Therapy as appropriate. Staff will continue to offer nutrition leadership and provide opportunities as nutrition preceptors. Breastfeeding and nutrition materials will be developed or revised as needed. New materials will be developed for Medical Nutrition Therapy. Staff will continue to emphasize and develop a fruit and vegetable promotion program. The following programs will continue to have liaisons from the Section: Partnership for a Fit Kentucky, Folic Acid and Prematurity Partnership, Arthritis Partnership, KY Diabetes Network, Kentuckiana Lactation Improvement Coalition, Western KY Breastfeeding Coalition, Coordinated School Health Coalition, AHEC, March of Dimes and the KY Food Security Partnership. The staff will continue to provide a nutrition focus in the employee wellness program and health fairs. Nutrition information and displays will continue to be provided at the State Fair as funding permits. The staff will assist in the implementation of the Electronic Benefits Transfer component of WIC. //2010//

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			22	22	21
Annual Indicator		23.4	24.0	22.5	23.0

Numerator		12285	13092	13084	12572
Denominator		52545	54614	58164	54634
Data Source					KY Vital Statistics files, live birth certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	19	19	18

Notes - 2008
2008 data is preliminary and numbers could change.

The annual indicator increased and the annual performance objective was set at an decrease and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2007
2007 data is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

a. Last Year's Accomplishments
/2010/ The GIFTS (Giving Infants and Families Tobacco Free Starts) Program is a smoking cessation program for pregnant women in the local health departments of 9 rural counties of eastern Kentucky that was implemented on February 11, 2008. The ultimate goal is to see a reduction in low birth weight and preterm births as well as perinatal deaths in the targeted area. The data that is reflective of February 11, 2008 through December 31, 2008 is included in the GIFTS Data presentation. More information about this program is identified in the attached Kentucky GIFTS presentation and can also be located at www.mcuky.edu/KYgifts

According to the 2008 BRFSS, Kentucky ranks third (in the United States) in current adult smoking at 25.2%. However, the smoking prevalence in women of childbearing age in KY dropped from 34.3% in 2007, to 31.5% in 2008. This trended across all childbearing age groups and is a hopeful sign.

2008 Kentucky Youth Tobacco Survey: Middle School current smokers 9.7% compared to 12.1% in 2006. Since 2000, middle school smoking has declined 56%. High School current smokers 26.8% compared to 24.5% in 2006. Since 2000, high school smoking has declined 28%.

Regional youth advocacy training for the last five years culminating in a web page for youth groups to connect across the state. Youth can post their activities and photos on the site. The movement name is H.O.T. (Helping Overcome Tobacco).

A revision was made in the Public Health Practice Reference that every pregnant woman who presents to the local health department should be assessed about their use of

alcohol, tobacco, secondhand smoke exposure, and other drug use at each health department visit and provided education and referrals.

Every LHD continues to offer smoking cessation programs/classes, that are available to anyone referred from doctor's offices or other community agencies.

The DPH provided a free Prenatal and Postpartum Training for LHD staff which does include education about smoking and pregnancy.

The DPH conducted a PRAMS (Pregnancy Risk Associated Monitoring Systems) pilot study. Several questions were included in the survey regarding smoking in pregnancy. Thirty-five percent of the completed surveys report smoking during the last three months of pregnancy. The data received from these questions will be reviewed and interventions will be identified that can be utilized statewide to decrease the percentage of women who smoke during pregnancy. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuation of GIFTS Program targeting pregnant smokers with a goal to see a reduction in low birth weight and preterm births as well as perinatal deaths in the 9-county targeted area	X	X	X	X
2. Tobacco Control Coordinators located in local health departments and patients screened at each visit about tobacco use and second-hand smoke exposure	X		X	X
3. Kentucky's Tobacco Quit line, 1-800-QUIT NOW; 30 Quit Line billboards posted across Kentucky	X		X	X
4. Quit Line promotional toolkit provided to local health departments, hospitals, businesses, Kentucky Cancer Program (UK and U of L), Cancer Information Service		X	X	X
5. Quit Line PSA's developed and distributed to local health departments		X	X	X
6. Local health departments offer Cooper Clayton Method to Stop Smoking 12 week cessation program at no cost to participants.	X		X	X
7. Regional youth advocacy training conducted over last 5 years has resulted in a web page for youth groups to connect across the state. This movement is named H.O.T. (Helping Overcome Tobacco)		X	X	X
8. Partnership with KMA to assist physicians in counseling patients to quit smoking	X	X	X	X
9. Training for local health department staff in Make Yours A Fresh Start Family and health departments providing Make Yours A Fresh Start Family counseling and services	X	X	X	X
10. DPH conducted a PRAMS (Pregnancy Risk Associated Monitoring Systems) pilot study soliciting responses to questions regarding smoking in pregnancy. This data will be collected to identify interventions that can be utilized statewide to decrease smokin		X	X	X

b. Current Activities

/2010/ Currently, 21cities/counties in Kentucky have smoke free laws covering approximately 38% of the state's population. The Tobacco Program contracts with the Kentucky Center for Smoke free Policy to provide training and technical assistance to local governments, health departments, and coalitions.

Reducing Pediatric Exposure to Secondhand Smoke. The Kentucky Chapter of American Academy of Pediatrics asked DPH to assist them in meeting their quality improvement goal for 2009. The project includes 7 practices; each will receive training, a toolkit, and materials to assist them in counseling patients and caregivers. Evaluation includes a survey and chart reviews.

he DPH provided a free Prenatal and Postpartum Training for LHD staff which does include education about smoking and pregnancy.

The GIFTS (Giving Infants and Families Tobacco Free Starts) Program still continues in the nine original eastern KY counties. The GIFTS Data presentation includes the data reflective of January 1, 2009 through April 30, 2009 and the data for a full calendar year of the GIFTS program (February 11, 2008 to February 28, 2009). //2010//

c. Plan for the Coming Year

/2010/ The GIFTS Program will be expanded to a metropolitan county. Data collected will help us determine the cost and effectiveness of rural versus urban. The only difference in implementation will be that current staff and student nurses will be the care coordinators (case managers) in lieu of hiring new staff.

Diabetes & Tobacco Collaboration to increase cessation counseling and quit line referrals by diabetes educators. Quit linen callers are asked who referred them and if they have ever been diagnosed with diabetes (question is identical to BRFSS question). Baseline data will be collected prior to training diabetes educators.

Healthy Communities is a new grant from CDC that includes physical activity, nutrition, and tobacco use. Small grants will be award to three cities/counties to develop and implement policies and programs in one or more of the three focus areas. Training and technical assistance will be provided to the selected cities/counties as well other interest cities/counties.

24/7 Tobacco-free Schools. Coordinated School Health, the Tobacco Program, Kentucky ACTION, the Tobacco Program, and Northern Kentucky Independent Health District tobacco program are jointly planning a 24/7 Tobacco-Free Schools initiative. The group will hold local meetings with school officials to encourage implementation. A grant application was submitted by Kentucky ACTION to CDC that will include a media campaign and staff to assist with promotion and implementation.

EX Campaign: Kentucky will join the National Alliance for Tobacco Cessation to participate in the EX Campaign which includes media (television, radio, posters, wallet cards, etc.) and a web page to help smokers quit and drive calls to 1-800-QUIT NOW. The quit line is a national portal that directs calls individual states' quit lines. The campaign will begin fall 2009. Kentucky is joining 17 other states in the Alliance and plans to make a 2-year commitment.

Every LHD will be encouraged to continue to offer smoking cessation programs/classes and assess every pregnant woman for smoking and exposure to secondhand smoke at each health department visit.

The DPH will provide the free Prenatal and Postpartum Training for LHD staff. Courses will be provided to raise awareness and educate staff on the effects of smoking and secondhand smoke exposure during pregnancy. //2010//

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	8	7.9	7	7	8
Annual Indicator	10.0	7.9	10.0	10.6	8.9
Numerator	29	22	28	30	25
Denominator	289004	278234	278933	282187	282187
Data Source					KY vital stats death cert files & U.S. census bure
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	7.5	7.5	7	7

Notes - 2008
2008 data is preliminary and numbers could change. 2008 population estimates are currently not available therefore, 2007 population estimates were used for the denominator.

Notes - 2007
2007 data is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

Future objective were reviewed but were not changed because 2006 data is preliminary and number could change.

a. Last Year's Accomplishments
/2010/ A progress report by the Kentucky Suicide Prevention Group (KSPG) reflects the many accomplishments of the state. In 2007 Kentucky had a reported suicide rate of 10.6 per 100,000 among youths aged 15 through 19. Through efforts of KSPG and other groups committed to lowering Kentucky's suicide rate, we saw a reduction in 2008; 10.6 per 100,000 among youths aged 15 -- 19. In 2008 there were 225 Question, Persuade, and Refer (QPR) sessions held by which 3,620 people were trained. QPR is a popular community gatekeeper 90 minute training program designed to create increased awareness about the signs and symptoms of a suicidal crisis and provide a network of

informed gatekeepers which allows for early detection, intervention and referral in order to avoid advanced crisis. Kentucky now has over 270 certified QPR instructors, more than any other state. Kentucky also has three Master QPR Trainers; more than any other state. KSPG collaborated with the department for Mental Health, Developmental Disabilities and Addiction Services (MHDDAS) to launch the "Let's Talk" campaign. "Let's Talk" is a short video where Kentuckians share stories about how suicide has touched their lives. As part of the campaign a Kickoff event was hosted at the Capital Plaza Hotel Ballroom, in Frankfort, KY for the premier showing of the Kentucky made DVD: "Kentuckians Affected by Suicide End the Silence". During the Kickoff event, Community Tool Kits were distributed in an effort to stimulate grassroots prevention efforts.
Prior to Suicide Prevention Week, KSPG mobilized over 60 volunteers to man the first time ever suicide prevention/awareness booth at the Kentucky State Fair.
For Suicide Prevention Week, September 7 -- 13th there was an intensive effort to distribute suicide prevention literature. A total of 45, 398 pieces of literature were disseminated throughout the State as a result of requests made to the Department, consisting of "Let's Talk" T-shirts, brochures and newsletters, depression and suicide prevention pamphlets, suicide symptom and warning cards, and Lifeline 1-800-273-TALK magnets.
A new marketing product was created, a new KSPG website: www.kentuckysuicideprevention.org. Here the "Let's Talk" theme is continued to raise awareness in the general public, a community calendar is provided as well as a list of training opportunities, clips are provided of the "Let's Talk" video, and there are additional resources provided for KSPG members and QPR instructors. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with the Department for Mental Health, Development Disabilities, and Addiction Services on Suicide Prevention Workgroup and Child Fatality Review Team			X	X
2. Increased public awareness of suicide through media campaigns			X	X
3. Identification and coordination of resources for suicide prevention activities		X	X	X
4. Identification of intervention options and training resources		X	X	X
5. Enhanced Mental Health initiatives through KIDS NOW!	X	X	X	X
6. Well Child and Adolescent Preventive Health training for local health department staff	X	X	X	X
7. Funding through SAMHSA for youth suicide prevention			X	X
8. Kentucky Suicide Prevention members working with school districts to work with survivors, provide resources and create media opportunities		X	X	X
9. Through collaboration with the Kentucky Suicide Prevention Group, trained over 3600 people on Question, Persuade, and Refer (QPR) gatekeeper program designed to create awareness about signs and symptoms of a suicidal crisis	X	X	X	X
10.				

b. Current Activities
/2010/ Kentucky has two Federal suicide prevention grants and one pending grant:
•SPYCE
•Campus Awareness to Suicide and Emergencies (UK-IN-CASE)

•SPEAK

KSPG holds monthly meetings in Frankfort. QPR trainings continue and thus the number of citizens prepared to intervene in a crisis grows. KSPG will have a booth at the Kentucky State Fair for Suicide Prevention Week again this year, staffed by volunteers. Another annual progress report will be published later this year. KSPG is working with communities to start local coalitions. Additional trainings including clinical, means restriction, and work with middle schools and high schools to get school-based prevention programs are being conducted, such as Signs of Suicide (SOS), an evidence based program aimed at educating students to recognize a friend in crisis, and get them help. A continued partnership with the armed forces to help deal with suicide will be a point of focus for 2009. KSPG is also working to expand resources available to suicide survivors.//2010//

Currently, the second leading cause of death in the 15-17 age group is suicide. Specifically, 15 year olds have the highest rate of suicide deaths, at 7.4 per 100,000. //2010//

c. Plan for the Coming Year

/2010/ Most of the current work of KSPG will continue through 2010. Additional activities may occur as time and money allow. KSPG will continue its monthly meeting in Frankfort. The popular QPR trainings will continue. KSPG plans to have a booth at the Kentucky State Fair for Suicide Prevention Week each year. The annual progress report will be published each year. Work will continue with communities to start local coalitions. The clinical and means restriction trainings and the work with middle schools and high schools for school-based prevention programs will be in place and it is hoped this will be a continuing program. The partnership with armed forces will continue.

Funding for the current grant ends September 2009. KSPG will be asking for a no-cost extension and will use up whatever funds are left over from this year. They have reapplied for this grant for 2009 -- 2012, but will not know until September if they will receive it. //2010//

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	61	64	82	70	55
Annual Indicator	73.8	60.0	54.6	54.9	54.8
Numerator	669	452	419	437	414
Denominator	906	753	767	796	755
Data Source					KY vital stats live birth cert files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	56	56	58	58	60

Notes - 2008
2008 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2008 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

Notes - 2007
2007 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2007 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

Notes - 2006
KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

2006 data is preliminary and numbers could change. Total birth files have not been received yet, therefore, numbers are lower than expected. The percentage will most likely decrease when files are complete. Due to this, it appears Kentucky has met the Annual Performance Objectives, when in reality, we have not. Therefore, the Objectives have not been increased.

Future objectives were reviewed but are unchanged because the 2006 data is preliminary and number could change.

Data for 2006 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

a. Last Year's Accomplishments
/2010/ Regionalized Neonatal Care: General Information
Five Kentucky hospitals qualify as Level III Neonatal Hospital facilities, King's Daughters in Ashland (with 1 Level III bed), the University of Kentucky in Lexington, the University of Louisville in Louisville, Norton/Kosair in Louisville, and Suburban in Louisville. A total of 117 beds are licensed for care under the Level III designation. Additionally, 221 beds are licensed for care under the Level II designation; these hospitals are distributed throughout the state while the Level III hospitals cluster in the two major population center: Louisville and Lexington.

Kentucky requires a Certificate of Need for NICU beds. Requests must be consistent with the State Health Plan. According to the State Health Plan, the number of Level III NICU

beds is determined by a calculation based on the total annual births in the state while the number of Level II NICU beds is based by calculation using the number of total annual births to an area development district.

The Office of Certificate of Need within the Cabinet for Health and Family Services is responsible for working with local hospitals. Currently, the Office of Health Policy encourages hospitals to apply for Level II NICU beds, as more beds in rural areas are seen as more accessible care. Local hospitals must commit to standards consistent with the National Guidelines for Perinatal Care, Sixth Edition, published jointly by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. However, once the CON is obtained, there is no reporting or oversight of these units.

Last Year Accomplishments 2008
The Perinatal Advisory Task Force did complete the drafting of Kentucky-specific Guidelines for Perinatal Care. Although these guidelines were not officially endorsed or implemented by the cabinet, they were reviewed by professional organizations. Objections came from hospital administrators and clinicians who did not want criteria for transport to be regulated. However, it has raised the issue and discussions are ongoing.

The Kentucky Perinatal Association hosted its annual conference designed for physicians, nurse practitioners, multidisciplinary perinatal professions, credited nurse midwives, and social workers interested in learning how to deal with the current issues related to perinatal care. Staff from the Department for Public Health did attend the conference and the Keynote address was delivered by the MCH Director for the Department for Public Health regarding "Regionalization of Perinatal Care". //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. On-going training for health professionals working with neonates	X		X	X
2. Perinatal Advisory Task Force designing reporting, oversight, and guidelines for services and transport				X
3. Collaboration with the Kentucky Hospital Association				X
4. Preconceptual health services through WIC, prenatal services, folic acid supplements	X	X	X	X
5. Collaboration Family Planning and preconceptual health counseling	X		X	X
6. Support of maternity and prenatal servcies through the local health department	X		X	X
7. Early Entry into prenatal care	X	X	X	
8.				
9.				
10.				

b. Current Activities
/2010/ A Perinatal Quality Collaborative is being discussed for Kentucky. The Department for Public Health has contracted with the University of Kentucky and the University of Louisville to provide a leadership role in the establishment and ongoing maintenance of the Perinatal Quality Collaborative. They have sought input from Ohio, Tennesse, and North Carolina perinatal quality collaboratives. The Kentucky Perinatal Association has established a committee to lead the effort.

Also, the Kentucky Medical Association Committee on Maternal and Infant Health has re-activated and will promote this approach to quality improvement.

The Department for Public Health is also working with the University of Kentucky and the University of Louisville to develop a consistent collection of outcomes for the highest risk NICU babies through their neonatal follow-up programs, using consistent measures and time frames for assessment so that outcomes data can be aggregated and compared.

c. Plan for the Coming Year

/2010/ The Department for Public Health (DPH) hope to move to regional or state-wide quality improvement activities, even if only on a small scale to start with. Perinatal outcomes and quality indicators will continue to be monitored and reviewed in order to improve perinatal outcomes in KY. The DPH will encourage Neonatal Intensive Care Units to host FIMR case reviews for infants from their area. This would give them a better idea of what happens to the infants that go home from their units, and identify strengths and weaknesses of the perinatal systems of care in their communities.

The Department for Public Health (DPH) hopes to move to regional or state-wide quality improvement activities Perinatal outcomes and quality indicators will continue to be monitored and reviewed in order to improve perinatal outcomes in KY. The DPH will encourage Neonatal Intensive Care Units to host FIMR case reviews for infants from their area. The DPH will encourage FIMR programs to collaborate with hospital chaplains and staff from the hospital bereavement services to participate and support the FIMR program within their local communities. This would give them a better idea of what happens to the infants that go home from their units, and identify strengths and weaknesses of the perinatal systems of care in their communities. //2010//

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	85.9	86	78	80	75
Annual Indicator	74.6	73.5	72.5	72.4	72.0
Numerator	39863	39414	40927	41103	38222
Denominator	53425	53646	56443	56749	53085
Data Source					KY Vital Statistics Live Birth Certificate files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	76	76	78	78	80

Notes - 2008
2008 data is preliminary and numbers could change

The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. A new method for calculating this indicator was provided to Region IV and adopted by KY and applied to the 2004-2007 data which was based on methodology developed by a programmer with the National Center for Health Statistics. This could be a possible reason for the decline observed.

Notes - 2007
2007 data is preliminary and numbers could change.

The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. A new method for calculating this indicator was provided to Region IV and adopted by KY and applied to the 2004-2007 data which was based on methodology developed by a programmer with the National Center for Health Statistics. This could be a possible reason for the decline observed.

Notes - 2006
2006 data is preliminary and numbers could change.

The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. A new method for calculating this indicator was provided to Region IV and adopted by KY and applied to the 2004-2006 data which was based on methodology developed by a programmer with the National Center for Health Statistics. This could be a possible reason for the decline observed.

a. Last Year's Accomplishments
/2010/ At the local level, all health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits is being processed. This information and process was emphasized during a nurses meeting through a live video conference available to all LHD nurses and at the annual Prenatal and Postpartum Training provided to the LHD nursing staff.

Local health department staff will continue to provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program. In addition, local health department staff will make an appointment or a referral for the pregnant woman for prenatal services, as well as assisting Medicaid eligible pregnant women to access services.

Some local health departments have paid for prenatal services out of their community funds for uninsured pregnant women (i.e., the undocumented Hispanic population). This financial burden has been greater in some counties than others. The Division of Maternal and Child Health has attempted to alleviate some of this financial burden by allocating specified funds to the local health departments.

The DPH conducted a PRAMS (Pregnancy Risk Associated Monitoring Systems) pilot study following the guidelines from the Centers for Disease Control and Prevention (CDC) PRAMS core and standard questionnaires. Questions on access to care were included in the PRAMS Pilot survey and 600 surveys were sent out and sampling was conducted from September through November.

The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. A new method for calculating this indicator was provided to Region IV and adopted by KY and applied to the 2004-2007 data which was based on methodology developed by a programmer with the National Center for Health Statistics. This could be a possible reason for the decline observed.
//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support fo maternity and prenatal services through the local health department funded by Title V	X		X	X
2. Presumptive Medicaid eligibility for pregnant women in collaboration with Medicaid Services		X	X	
3. Continuation of Substance Abuse Cessation project funding through KIDS NOW!		X	X	
4. Collaboration between Comprehensive Care Centers (Kentucky's mental health providers) and local health departments			X	X
5. HANDS Home Visitation services	X	X	X	
6. Tobacco cessation for pregnant women including the Quit-Line	X	X	X	X
7. Centering Pregnancy Programs	X	X	X	
8. Healthy Start program in Whitley County and the Louisville Metro area	X		X	
9.				
10.				

b. Current Activities

/2010/ DPH conducted a PRAMS (Pregnancy Risk Associated Monitoring Systems) pilot study, of which 600 surveys that were sent out, over 400 completed PRAMS surveys were returned to DPH. The data analysis was completed and a report was published. The most significant barrier to early entry into prenatal care was access issues. From those pregnant women who wanted to receive care, the following barriers were identified: 40 % report they did not have a medical card, 27.6% reported they did not have enough money, and 22.8% of the women reported they could not get appointment. This information will be reviewed and interventions will be identified that can be utilized statewide to increase early entry into prenatal care.

DPH is currently an additional PRAMS (Pregnancy Risk Associated Monitoring Systems) pilot study with the intention of applying for CDC funding when grant applications are available. The final surveys will be sent in October 2009. A report should be available in 2010.

The FY09 contract between the University of Kentucky Area Health Education Center (AHEC) and the North Central AHEC was renewed. Education will be targeted toward prematurity prevention and early entry into prenatal care through the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit. //2010//

c. Plan for the Coming Year

/2010/ Local health departments and communities will be encouraged to emphasize prematurity prevention and early entry into prenatal care through the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit.

Upon the data analysis and release of the 2010 PRAMS report, this information will be reviewed and further interventions will be identified that can be utilized statewide to increase early entry into prenatal care.

The health department staff is educated and encouraged to begin referral for prenatal care upon a positive pregnancy test. Continuing education will be provided to the health department staff regarding Presumptive Eligibility to help ensure early access to prenatal care.

DPH is working collaboratively with partners such as the March of Dimes (MOD), Kentucky Perinatal Association (KPA), physicians, hospitals and the Kentucky Folic Acid Partnership (KFAP) to achieve the following goals:
Raise public awareness about the problem of prematurity, educate pregnant women to recognize signs of premature labor, assist health care practitioners to improve prematurity risk detection and address risk-associated factors, and expand access to healthcare in order to improve prenatal care and birth outcomes. //2010//

D. State Performance Measures

State Performance Measure 1: *Decrease the death rate for children age 0-18 due to unintentianal injury and/or violence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			9	9	9
Annual Indicator	11.0	10.9	21.3	17.4	15.4
Numerator	116	114	225	184	163
Denominator	1052419	1049314	1056466	1058380	1058380
Data Source					KY Vital Statistics Death Certificate Files and U.
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15	14	14	12	12

Notes - 2008
2008 data is preliminary and numbers could change.

For consistency in reporting of this indicator, ICD10 codes were based on the Unintentional injury and violence codes as used in the CDC WISQARS reporting tool beginning with the 2006 data. In past years, the same ICD10 codes may not have been used and this could have caused the rise in the death rates.

For years 2006 and forward, ICD10 codes used in calculating this indicator were: V01-X59, Y85-Y86, X60-X84, Y87.0, X85-Y09, Y87.1, Y35, and Y89.0.

Data Source: KY Vital Statistics Files, Death certificate files, & U.S. Census Bureau Population Estimates for KY. 2007 Population estimates were used for 2008 as 2008 estimates are currently not available.

Notes - 2007
2007 data is preliminary and numbers could change.

For consistency in reporting of this indicator, ICD10 codes were based on the Unintentional injury and violence codes as used in the CDC WISQARS reporting tool beginning with the 2006 data. In past years, the same ICD10 codes may not have been used and this could have caused the rise in the death rates.

For years 2006 and forward, ICD10 codes used in calculating this indicator were: V01-X59, Y85-Y86, X60-X84, Y87.0, X85-Y09, Y87.1, Y35, and Y89.0.

Data Source: KY Vital Statistics Files, Death certificate files, & U.S. Census Bureau Population Estimates for KY.

Notes - 2006
For consistency in reporting of this indicator, ICD10 codes were based on the Unintentional injury and violence codes as used in the CDC WISQARS reporting tool beginning with the 2006 data. In past years, the same ICD10 codes may not have been used and this could have caused the rise in the death rates.

For years 2006 and forward, ICD10 codes used in calculating this indicator were: V01-X59, Y85-Y86, X60-X84, Y87.0, X85-Y09, Y87.1, Y35, and Y89.0.

Data Source: KY Vital Statistics Files, Death certificate files, & U.S. Census Bureau Population Estimates for KY.

a. Last Year's Accomplishments

/2010/ Throughout the year the State Child Fatality Review (CFR) Team continued to strengthen and meet on a regular basis. Invitations were made at times to content experts to attend selected meetings such as the January 2009 fire meeting. The State CFR team continued support of and individualized training for the local CFR teams. The State CFR team participated in four Prevent Child Abuse Kentucky funded child abuse/CFR regional trainings. In the Spring of 2008 we were successful in passing a state booster bill after seven years. The Bill was implemented in July 2008 with warnings only, for full enforcement starting in July 2009. In June 2008 we were successful in securing approximately $17,000 of Safe Kids Buckle Up Program funding for July 2008 -- July 2009 child passenger safety work in five rural counties and throughout the state under Kentucky State Safe Kids. //2010//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Fatality Review and Injury Prevention program.		X	X	X
2. Healthy Start in Childcare program working with preschools, assuring training and safety in the preschool setting.	X	X	X	X
3. Injury Prevention Partners including Safe Kids Coalitions, Poison Control Center, the SIDS Alliance, Kentucky Injury Prevention Research Center, and Kentucky Center for School Safety.			X	X
4. HANDS voluntary home visitation program	X	X	X	X
5. Substance Abuse education and treatment	X		X	X
6. Passage of Child Booster Seat Bill; legislation for Safe Haven, ATV Helmet useage, Graduated Driver's License, and Primary Seatbelt		X	X	X
7. Partnership with the Department for Education for Coordinated School Health		X	X	X
8. Partnership with Prevent Child Abuse Kentucky and the Department for Community Based Services		X	X	X
9. Training provided to Well Child and Adolescent Preventive Health Nurses and Oral Health providers to recognize the signs of Domestic Violence		X		X
10. Injury Prevention programs including Child Passenger Safety Seat Checks, ATV and Hunter Safety classes, Back to Sleep campaign, Smoke Alarm usage, Safe Sleep Environment, SIDS, Shaken Baby, Underage Drinking, Bullying,a nd Seatbelt Usage	X	X	X	X

b. Current Activities

/2010/ Efforts continue on educating the state on the Booster Seat bill. The bill was passed by the Kentucky General Assembly in 2008 but does not become a punishable crime until July 1, 2009. Beginning July 1 the law will be enforced and those caught driving without having their children properly restrained will receive a monetary fine.

Sudden Unexplained Infant Death (SUID) continues to be an area of high concern in Kentucky as the state's numbers remain above the national average. Therefore, Kentucky has applied to be one of seven states to take part in a SUID Registry. Work will begin on this project in August 2009 and will help to increase knowledge about the prevalence, causes and potential preventive strategies related to SUID in Kentucky.

The Director of Maternal and Child Health, the state CFR program coordinator and other important party members recently discussed the CFR program, its process, and changes we would like to make. Our goal is to have every child death case reviewed. We have agreed to screen every case and divide into subgroups for further screening. Every case will either be reviewed at the local level or by the state team. Follow-up conducted at the state level will ensure local teams are reviewing appropriate cases. The state screening process will also ensure pertinent information for each case gets to the local level if not reviewed by the state team. Local teams wil be encouraged to work toward preventive efforts. //2010//

c. Plan for the Coming Year

/2010/ State goals include continued expansion of the SUID registry. The calendar year for the registry will run from August to July. The plan is to have the number of SUID in Kentucky that are reported to the registry within one week of occurrence at 90% by July 31, 2010. Within this plan is to have the number of Kentucky SUID cases reviewed by a multidisciplinary SUID State Case Review Team at 90%, the number of Kentucky SUID cases that are entered into the electronic web-based registry within three months of occurrence at 90%, the number of cases entered in the registry with complete data at 85%, and the number of educational activities related to the Kentucky SUID registry at 5. During the year 2010 Kentucky will work on increasing all of those objectives with percentages by 5% and the educational activities by 3 for the end date of July 31, 2011. Additionally in 2010 we will begin one extra task. Between 8/1/2010 and 7/31/2011 we will complete a minimum of seven educational activities about the Kentucky SUID registry to public and professional stakeholders.

The Director of Maternal and Child Health, the state CFR program coordinator and other important party members recently held a meeting to discuss the CFR program, its process, and changes we would like to make. Our goal is to have every child death case reviewed. We have agreed to screen every case and divide into subgroups for further screening. Every case will either be reviewed at the local level or by the state team. Follow-up will be conducted at the state level with the local teams to ensure they are reviewing their appropriate cases. This screening process at the state level will also ensure any pertinent information for that case will get to the local level if it is not reviewed by the state team. We will encourage the local teams and the state team to work toward preventive efforts from their reviews.

The formation and training of local CFR teams will continue to be a priority. Kentucky plans to have at least 90 counties with active Child Fatality Review teams by the end of 2010. Evidence from the survey sent out in March by the CFR program coordinator shows there are at least 56 counties with active CFR teams, with another 10 -- 15 that have expressed an interest in starting a team.

For future consistency in reporting of this indicator, ICD10 codes will be based on the Unintentional injury and violence codes as used in the CDC WISQARS reporting tool beginning with the 2006 data. In past years, the same ICD10 codes may not have been used and this could have caused the fluctuation in indicators.

ICD10 codes used in calculating this indicator were: V01-X59, Y85-Y86, X60-X84, Y87.0, X85-Y09, Y87.1, Y35, and Y89.0. These codes will be used in future reporting. //2010//

State Performance Measure 2: *Reduce the rate of substantiated incidence of child abuse, neglect, or dependency.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	16	15	9.4	14	14
Annual Indicator	18.4	18.9	19.1	18.5	14.7
Numerator	18275	18827	19003	18469	14802
Denominator	993875	996407	996407	999531	1003973
Data Source					Dep. for Community Based Services TWIST database o
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	12	10	10	10

Notes - 2008
2008 population estimates are currently not available therefore, 2007 estimates were used for the denominator.

Notes - 2006
Data is from TWIST data from 7/1/2005 to 6/30/2006. Denominator is total children in Kentucky ages 0 to <18. Numerator is total number of investigated children substantiated for child abuse and/or neglect. Due to staff changes, data may not have been consistently reported in previous years, which could explain the varying numbers from 2002 to 2004. Data from 2004 to 2006 was reviewed with DCBS staff and verified. Data source is Child Abuse and Neglect of Child Fatalities and Near Fatalities, State Fiscal Year 2006 (July 1, 2005 to June 30, 2006). This report is submitted annually to the governor.

a. Last Year's Accomplishments
/2010/ According to the KIDS NOW Early Childhood Initiative Summary dated March 2009, in FY 2009, 9,961 families participated in HANDS. All 120 counties were participating and 4563 assessments were conducted, 48,353 professional home visits and 64,305 paraprofessional home visits were conducted. //2010//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continuation of HANDS Voluntary Home Visitation Program	X	X	X	X
2. Child Fatality Review Data System for on-going surveillance of child deaths			X	X
3. Healthy Start in Childcare program to work with preshools, assuring training and safety in the preschool setting			X	X
4. On-going monitoring of HANDS data and HANDS evaluation process				X
5. KIDS NOW! Early Childhood Mental Health and continuation of teh Mental Health in Child Care Initiative	X		X	X
6. Training provided to Oral Health providers and local Health Department nurses to recognize the signs of domestic violence		X	X	X

7. Substance Abuse education and treatment	X		X	X
8. Partnership between the Department for Public Health, the Commission for Children with Special Health Care Needs and the Department for Community Based Services for injury prevention programs		X	X	X
9. Partnerships with Kentucky Injury Prevention Research Center, Prevent Child Abuse KY and KY Center for School Safety			X	X
10. Perinatal Depression Study through HANDS (HRSA Grant)	X	X	X	X

b. Current Activities

/2010/ New public relation materials (brochure and poster) were developed with focus on prenatal entry into the program.
3rd Annual HANDS Training for 400 home visitors and supervisors occured in April and featured T.Berry Brazelton and Harvey Karp.
Participated in parent assessment tool study referred to as KIPS (Keys to Interactive Parenting)
Development of Technical Assistance Training was completed
On-line home visiting safety training module was completed
On-line orientation into HANDS was completed
Work has begun on a web-system for centralization and up to date information on technical assistance site visits documentation. //2010//

c. Plan for the Coming Year

/2010/ Plans for upcoming year:

Possible expansion to all families with President's 2010 budget
Evaluation web-system upgrade scheduled to be completed
Updates to policies and procedures
Collaboration with other data systems such as vital statistics, billing data, etc.
4th annual HANDS Academy planned for April 2010 //2010//

State Performance Measure 7: *Increase the percent of women of childbearing age that present to a local health department that receive a preconceptual service.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12	82	82
Annual Indicator		77.6	80.6	83.4	69.7
Numerator		177301	184168	158736	147291
Denominator		228567	228567	190233	211369
Data Source					KY Local Health Dep. reporting system (CDP)
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	72	72	74	74

Notes - 2006
This indicator has been changed since it was first developed in last years grant application. The 2005 data reflects women aged 15-44 in minority populations (any race/ethnicity except for Non-Hispanic Whites) that presented to the Local Health Department for a preconceptual service. This indicator was changed for 2006 to include any woman aged 15-44 regardless of race/ehtnicity that presented to the Local Health Department for any reason and received a preconceptual service. This indicator was changed due to the very small numbers of minority women of childbearing age presenting to the Local Health Department for services, and the new indicator will provide a better measure for women of childbearing age that receive preconceptual services regardless of their reason for presenting to the Local Health Department.

a. Last Year's Accomplishments
/2010/ The KY Department for Public Health houses many diverse programs that support CDC's preconceptional recommendations by developing interdepartmental initiatives focusing on interconceptional care for women. The collaborative initiatives recognize preconceptional care should not be limited to a single visit. All DPH health care programs identify having an impact on a women's optimal health and potential outcome of any planned or unplanned birth. Opportunities to discuss preconceptional health with patients during each program's clinical visits are identified through collaborative agreements during the developmental and approval process for all DPH policies and guidelines.

One DPH program having the most significant impact by reaching the greatest amount of women is the Family Planning Program. Housed within the Division of Women's Health, the Title X/Family Planning Program offers a full array of reproductive healthcare services to individuals of child bearing age. Funding for services is made available through federal Title X funds allocated to local health departments.

Services include: client education, counseling, medical history including reproductive and sexual, physical assessment and laboratory testing, fertility regulation, infertility services, pregnancy diagnosis and counseling, adolescent services, gynecologist services and sexually transmitted disease testing and treatment

Low-income, under or uninsured females, less than age 21, identified as having abnormal gynecological cancer detecting exams (breast and cervical) are provided treatment via use of Title V funds.

Special emphasis on preconceptional health, and benefits of birth spacing is given during preventive health counseling sessions.

In calendar year 2008,108,430 women, men, and adolescents were served through the Title X program.

Family Planning clients are provided counseling annually to promote preconception health. Counseling supports the recent CDC recommendations for preconception health.

Special initiatives targeted to service populations identified as having high social and medical risk for unintended pregnancy or poor birth outcomes (i.e. infant death, fetal loss, birth defects, low birth weight, or preterm birth) include:

One Title X clinic targeted to low income under insured Hispanics served 1,040 individuals adding to a statewide total of 8,623 Hispanic users. This statewide total in Hispanic clients was a 5.8% increase from calendar year 2007.

Community outreach efforts in urban areas contributed to providing services to 12,876 African/American clients.

A targeted Appalachian region known to have a higher STD and teen pregnancy rate, have proven with the Pike County Male Special Initiative Project that services need to expand beyond the local health department clinic, by reaching not only a college based clinic, but also an in-school program for middle school males who are taught goal setting and self-esteem skills. Total services provided to males age 15 and below were 3,241 and 210 males over age 15.
Two central KY Title X initiatives focus on teen pregnancy prevention, the Coalition for Adolescent Pregnancy Prevention (CAPP) (formally the Teen Pregnancy Prevention Intervention Program) and the University of Kentucky Young Parents Program (YPP). In CY 2008 CAPP served 299 females below age 20 and YPP served 1,229 females below age 20. Both agencies provide intensive counseling to teens to prevent teen pregnancies and repeat teen births and also comprehensive adolescent preventive health care services. YPP is unique because it places emphasis on medical, nursing, and nutritional care for both mother and child, education toward better parenting, career and educational counseling, psychosocial support of the family unit; and family planning services. //2010//

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Education and training for health care professionals in cultural diversity		X	X	X
2. Family Planning counseling and interconceptual spacing of children	X	X	X	
3. Access to care and early entry into prenatal care	X		X	X
4. WIC and Nutrition counseling	X	X	X	
5. Substance Abuse education and treatment	X	X	X	
6. Smoking cessation counseling	X	X	X	
7. Preconceptual counseling and Folic Acid supplements	X	X	X	
8. Community outreach efforts targeted to populations identified as having high social and medical risk for unintended pregnancy or poor birth outcomes	X	X	X	X
9. Targeted services to the Appalachian region to address the high STD and teen pregnancy rates	X	X	X	X
10. Two Central Kentucky initiatives to focus on teen pregnancy prevention	X	X	X	X

b. Current Activities
/2010/ Kentucky received $ 5,888,560 in federal Title X funding for FY09. Kentucky funds 170 Title X clinics, with the majority of this funding allocated to local health departments to assure access to family planning services throughout Kentucky's 120 counties. Additionally, local health departments may opt to use a portion of their federal Title V Block Grant allocation to support family planning program efforts in their community. In FY 08 local health departments used $1,713,184 of Title V funds to supplement their family planning programs. All Title X delegate agencies must offer all methods of FDA approved contraceptives, including emergency contraceptive pills. Title X funding does not fund abortions.

Recent interconceptional collaborations with other MCH programs include: a.) All family planning women receiving a pregnancy test also receive a lead exposure verbal risk assessment. Those women identifying with a high risk are recommended for follow up screening; b.) Women of childbearing age are counseled on the importance of folic acid and receive folic acid supplementation; and c.) Kentucky's largest metropolitan area,

Jefferson Co benefits from the Healthy Start Program, a federally funded initiative mandated to reduce the rate of infant mortality and improve perinatal outcomes. The program focuses on Five Core Service interventions: direct outreach; case management; health education, interconceptional care; and screening for depression.(See Attachment) //2010//

c. Plan for the Coming Year
/2010/ Kentucky's 2009 Family Planning Program's goals are:

To assure access to comprehensive quality family planning services to individuals, families, and communities through outreach to hard-to-reach or disparate populations and partnering with community-based health and social service providers.
To provide comprehensive reproductive preventive services to enhance the health of Kentucky women and families as demonstrated in improved prematurity rates, STD prevalence, cancer screenings and decreased teen pregnancy and birth rates.
To assist women, teens, and men to prevent unintended pregnancy and plan healthy pregnancies.

To help meet these goals, Title X the program must continue to market services through community participation committees and community plans; prepare or recruit additional providers; continue outreach to hard-to-reach and vulnerable populations in non-traditional service sites already established; and expand non-traditional sites to new areas.

In 2008, the Healthy Start Program will continue to:

Increase the number of disparate populations seeking services particularly African-American pregnant clients
Reduce poor pregnancy outcomes such as low birth weights
Increase the number of women initiating prenatal care in the first trimester
Increase the number of women receiving preventive care services after delivery
Zero infant mortality to Healthy Start Participants

DPH Programs such as MCH, Title X and Healthy Start will continue to collaborate on developing strategies to teach providers how to identify and utilize preconceptional reimbursement codes that will provide an avenue to collect data and track counseling. Title X/Family Planning clinics will continue to provide; medical counseling, all FDA approved contraceptive choices, preconceptional counseling, Pap tests, and STD testing including HIV. The new CDC recommendations regarding preconception health care, will dictate how DPH will continue to collaborate interdepartmentally to identify and strategize goals and objectives to assure healthy maternal and child health outcomes. //2010//

State Performance Measure 8: *Reduce the percentage of live births that are preterm.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			16	14	14
Annual Indicator	14.4	15.0	15.2	15.2	15.1

Numerator	8026	8398	8793	8961	8255
Denominator	55779	55990	57954	58952	54634
Data Source					KY vital stats live birth cert files
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	14	12	12	10	10

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
2007 data is preliminary and numbers could change.

a. Last Year's Accomplishments
/2010/ Accomplishments for 2008 include:
Utilization of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Tool Kit and implementation at three intervention sites in Kentucky to assist these communities to deliver a universal message/awareness about the issue of premature birth in Kentucky and interventions targeted toward prevention.

Training was provided on the use of the Healthy Babies Are Worth The Wait" Prematurity Prevention Tool Kit the health department nurses who attended the annual Prenatal and Postpartum Training.

The MCH Division Director continues to present an awareness prematurity campaign to prenatal health care providers and consumers in Kentucky.
The prenatal program in the local health departments continues to assess prenatal patients for preterm risk at the initial visit, and return visits for those women assessed at risk for preterm labor.

A guideline on preterm birth prevention continues to be included in the prenatal section of the Public Health Practice Reference to assist local health department prenatal staff. The mission of the prenatal program in the local health department is to assist pregnant women to access prenatal care services regardless of payor source. Title V funding is allocated each fiscal year to health departments to assist uninsured pregnant women in need of prenatal services.

The Kentucky Perinatal Association hosted its annual conference designed for physicians, nurse practitioners, multidisciplinary perinatal professions, credited nurse midwives, and social workers interested in learning how to deal with the current issues related to perinatal care. Staff from the Department for Public Health did attend the conference and the Keynote address was delivered by the MCH Director for the Department for Public Health regarding "Regionalization of Perinatal Care". Other presentations addressing the issue of prematurity included: "Challenges for Obstetricians in Preventing Late Preterm Birth", "Chronology of Preterm Birth Progression and Challenges Over the Past Two Decades", "Pregnancy, Prematurity and Polysubstance Abuse", "Developmental Care for Preterm Infants for Public Health Nurse and Other Health Care Professionals" and an update on the "Healthy Babies Are Worth the Wait."

Statewide prematurity awareness activities performed by the Kentucky Folic Acid Partnership included 345 activities with 4,833,147 participants. //2010//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration efforts with Kentucky Perinatal Association and the March of Dimes		X	X	X
2. Folic Acid Partnership Statewide Prematurity Awareness campaign			X	X
3. HANDS Home Visitation Program	X	X	X	X
4. University partnerships			X	X
5. Training provided to health care professionals			X	X
6. Continuing use of a Prematurity Took Kit and as speaker's bureau			X	X
7. Title V Director's prematurity presentations to professional organizations and consumers			X	X
8. "Babies are Worth the Wait" continues to be utilized at three intervention sites in the state	X	X	X	X
9.				
10.				

b. Current Activities

/2010/ The Department for Public Health provides a yearly Prenatal/Postpartum Training and Prenatal Update for LHD staff.

The prenatal program in the local health departments continues to assess prenatal patients for preterm risk at the initial visit, and return visits for those women at risk for preterm labor.

Statewide prematurity awareness activities performed by the Kentucky Folic Acid Partnership from January 1, 2009 through April 30, 2009 included 122 activities with 1,387,250 participants.

The Department for Public Health will encourage the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Tool Kit across the state of Kentucky as a model intervention to assist communities and providers to deliver a universal message/awareness about the issue of premature birth in Kentucky and interventions targeted toward prevention. This toolkit is being used to educate Hispanic lay workers to educate the Hispanic community within the Bluegrass Region of Kentucky through the collaborative efforts of the Department for Public Health and the AHEC Hispanic Health Education. //2010//

c. Plan for the Coming Year

/2010/ The Department for Public Health will provide a yearly Prenatal/Postpartum Training and Prenatal Update for LHD staff with sessions relating to prematurity prevention. The prenatal program in the local health departments continues to assess prenatal patients for preterm risk at the initial visit, and return visits for those women assessed at risk for preterm labor.

A guideline on preterm birth prevention continues to be included in the prenatal section of the Public Health Practice Reference to assist local health department prenatal staff. The mission of the prenatal program in the local health department is to assist pregnant women to access prenatal care services regardless of payor source. Title V funding is allocated each fiscal year to health departments to assist uninsured pregnant women in need of prenatal services.

The Department for Public Health will encourage the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Tool Kit across the state of Kentucky as a model intervention to assist communities and providers to deliver a universal message/awareness about the issue of premature birth in Kentucky and interventions targeted toward prevention. The use of this toolkit, as well as other educational resources regarding prenatal care and prematurity prevention, are available at the web site, www.prematurityprevention.org

The "Healthy Babies Are Worth The Wait" Prematurity Prevention 3 year campaign will conclude in December of 2009. Data obtained through the targeted prematurity prevention interventions will be analyzed. This information will be in reviewed in 2010 to enhance targeted prematurity prevention interventions throughout the state. The toolkit will continue to be utilized statewide. //2010//

State Performance Measure 9: *Percentage of foster care children served by the Commission for Children with Special Health Care Needs (CCSHCN)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			20	30	40
Annual Indicator		2.5	2.8	4.9	5.7
Numerator		164	182	368	424
Denominator		6600	6600	7500	7414
Data Source					CCSHCN and DCBS Databases
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	7	8	9	10

Notes - 2008
CCSHCN Database query: 6/30/08; DCBS FACTS 6/1/08

a. Last Year's Accomplishments
Services provided are as varied and individualized as the children in or at risk of foster care. While the anticipated impact outstrips realistic agency capacity, the percentage of children in foster care served by CCSHCN continued to increase steadily. Nurse consultants located in child welfare agency offices continued to serve as health care resources to social service workers covering the entirety of the Commonwealth during 2008. Children involved in foster care are also able to participate in a dedicated primary care clinic in Lexington, as well as specialty care clinics statewide. An array of augmentative services by professional staff are also available in a clinical setting. A dedicated Foster Care Support Branch serves as a clearinghouse of information and technical assistance to CCSHCN staff who may have questions.

In the past year, foster care nurses attended a wide variety of conferences and skill-building trainings related to the child welfare setting (for example, Toxicology & Drug Screening).

Additionally, they continued to provide trainings to youth in foster care on such topics as Nutrition and Sexually Transmitted Infections. Foster care nurses also provided peer-to-peer insight into the child welfare system to nursing colleagues in the context of providing local training on working with medically fragile resource homes.

Foster care nurses have made a special effort to remain visible in all counties in their assigned areas, making visits to all child welfare offices, attending scheduled foster parent training events, and other such activities. In addition to providing case-specific consultation on children in or at risk of out of home care and providing general information on medical concerns noted by child welfare staff, foster care nurses also initiated a formal effort to educate foster parents about and ensure the completion of Medical Passports which track health care provision.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide nursing consultation services	X		X	X
2. Conduct home visits in partnership with DCBS (child welfare) social service workers	X	X	X	X
3. Provide health education to foster families, child welfare workers, and youth	X	X	X	X
4. Provide care coordination for foster children and youth with special health care needs in a specialty clinical setting	X	X	X	X
5. Provide a medical home for foster children in the Bluegrass area	X		X	X
6. Support the creation and maintenance of a medical passport tracking health care provision for children in foster care	X			X
7.				
8.				
9.				
10.				

b. Current Activities

Nurse consultants continue to contribute medical insight on specific child welfare matters as requested. Due to budgetary limitations, CCSHCN's Foster Care Support Branch currently employs seven (7) nurse consultants as opposed to nine (9). The Northern Kentucky child welfare region is no longer served, and the Cumberlands area is now covered by nurses from contiguous areas.

Numbers served typically fluctuate somewhat based on referrals received. However, nurse consultants are available at any time to the child welfare system. Additionally, the Lexington CCSHCN district continues to house a primary care clinic for foster children (Medical Home for Coordinated Pediatrics), which operates every business day.

The Foster Care Support Branch continues to assist in problem-solving various issues related to the child welfare system for CCSHCN district staff (for example, questions about custody) upon request.

c. Plan for the Coming Year

CCSHCN and the state child welfare agency leaders are planning to meet in July, 2009, to discuss and evaluate the current Memorandum of Understanding between the agencies. Modifications may result. However, at this time, the program is functional in 8 of the 9 child

welfare service regions (covering 108 of 120 counties) in the Commonwealth, and at the state central office level. Nurse consultants continue to cultivate relationships with child welfare staff and become increasingly relevant contributors.

State Performance Measure 10: *Percentage of medically fragile foster children served by the Commission.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			30	45	55
Annual Indicator		5.6	85.7	78.1	83.2
Numerator		9	120	125	129
Denominator		160	140	160	155
Data Source					CCSHCN and DCBS Databases
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	85	86	86	87

Notes - 2008
6/4/08 CCSHCN Database census & 6/2/08 DCBS census

a. Last Year's Accomplishments
During fiscal year 2008, the number of children participating in the CCSHCN Medically Fragile Foster Care program increased even as the overall population of medically fragile children decreased slightly. Performance as measured by the annual indicator remained comfortably above the goal, for the third consecutive year. Due to a small but significant residual population of foster children who are placed out of state, in 24-hour medically-staffed facilities, or are otherwise ineligible for the program (for example children who are AWOL), participation will never reach 100%.

Newly-established protocols enable child welfare workers to involve CCSHCN nurse visitors early in the placement process so that they may provide a key voice on the child's health team when it is most needed. CCSHCN has developed, with the child welfare agency, language directing workers on how and where to send referrals. In the event that referrals are not received in a timely manner, the CCSHCN Foster Care Support Branch sends gentle reminders until the child is enrolled and active with a a nurse visitor. A dedicated program administrator serves the CCSHCN Foster Care Support Branch attending to day-to-day management of the Medically Fragile Foster Care program.

Regular communication continues both within the CCSHCN organization and across agency lines with contacts regionally and at the state office levels of the child welfare agency and includes periodic newsletters featuring topical field-generated questions and answers, highlighted resources and policy clarification; participation in meetings and conferences; and consultation on case-specific and more general topics as needed. Additionally, a resource section located on the agency intranet page (viewable by CCSHCN and child welfare staff) has been created and is devoted to the Medically Fragile Foster Care program.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Provide nursing consultation services	X		X	X
2. Conduct home visits in partnership with DCBS (child welfare) social service workers	X	X	X	X
3. Provide health education to foster families, child welfare workers, and youth	X	X	X	X
4. Assist with care coordination for medically fragile foster children and youth	X	X	X	X
5. Support the creation and maintenance of a medical passport tracking health care provision for children in foster care	X			X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CCSHCN and leadership of the state child welfare agency plan to meet in July, 2009, to discuss and evaluate program expectations, performance, and future directions. Some adjustments to the current Memorandum of Understanding between the agencies may result, particularly in light of the enactment of the recent federal Fostering Connections to Success and Increasing Adoptions Act requiring oversight and coordination of health care for children in foster care. At this time, the program is fully functional in 112 of the 120 counties in the Commonwealth, and at the state central office level, and it is widely acknowledged as a strength in both the public health and child welfare systems.

As the program nears its quantitative capacity and is no longer considered a "new" program, more robust quality assurance is envisioned. Nurse visitors continue to cultivate relationships with child welfare staff, youth in foster care, and foster parents and become increasingly relevant contributors. Nurse visitors collaborate with the child welfare system's Independent Living Program to ensure transitional information is discussed with families, i.e. transition checklists.

c. Plan for the Coming Year

Future initiatives will flow from upcoming collaboration between agency representatives. Some anticipated directions include the possibilities of overcoming interagency barriers and HIPAA provisions in order to facilitate an even simpler and automated referral process, which would eliminate delayed referrals and service implementation based on child welfare worker paperwork burden. Other activities under consideration include database improvements, continued technical assistance to field staff on qualitative issues, and improved communication with new child welfare central office medical support staff. The top priority for CCSHCN administrators is the continued provision of quality services to medically fragile youth in foster care.

State Performance Measure 11: *The number of Medicaid covered women who had at least one dental visit during their pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective				28	34
Annual Indicator			27.3	32.3	33.3

Numerator			9588	11972	12332
Denominator			35099	37053	36988
Data Source					KY Medicaid claims data warehouse
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	34	35	35	36	36

Notes - 2006
2006 data is preliminary and numbers could change.

a. Last Year's Accomplishments
/2010/ The University of Kentucky College of Dentistry continues the implementation and augmentation of the Centering Pregnancy programs at the Women's Health Center at the Trover Clinic in Madisonville and at the University of Kentucky. The Centering Program provided prenatal education and care for expectant mothers in small, peer-lead groups. Running concurrent to the group sessions are dental care appointments for the participants adjacent to the meeting room. Dental care for these women had emphasis on professional prophylaxis and stringent home care. Referrals for more complicated procedures were made as needed. Their goal continued to be 1000 participants each year. Centering Pregnancy is a national model, developed and tested by Yale University, with positive effects on birthing outcomes. Developments in Kentucky are coordinated with the continuing March of Dimes Initiative and the Department for Public Health. //2010//

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Kentucky Oral Health Program			X	X
2. Regional Dental Treatment Clinics, Primary Care Centers and local health department's oral health programs	X		X	X
3. Local Health department's prenatal programs	X		X	
4. March of Dimes, Johnson and Johnson Pediatric Institute and Department for Public Health demonstration projects in 3 regions of the state	X		X	X
5. HANDS Home Visitation Program	X	X	X	
6. Partnership with University of Kentucky and University fo Louisville Dental schools	X	X	X	X
7. Partnership with Medicaid and Medicaid Dental providers	X		X	X
8.				
9.				
10.				

b. Current Activities
/2010/ The KOHP collaborates with community partners to improve access to oral health care for pregnant women through the Centering Pregnancy with Smiles curriculum. These partners include Frontier Nursing Services at Hyden, the University of Kentucky Center for Rural Health in Hazard, the Women's Health Center in Madisonville's Trover Clinic and the University of Kentucky College of Dentistry.

The UK College of Dentistry is successful with self-sufficiency strategies through their "Centering Pregnancies with Smiles" program, a peer-led prenatal counseling and educational experience with a dental component. Medicaid recipients receive dental care, hygiene instruction and support. Participation is high, suggesting post-natal mothers have good oral hygiene, lower need for urgent dental care and lower decay rates among their offspring. Surveillance and research is

done by UK for this project which is executed at the Trover Clinic in Madisonville.

According to Medicaid data for the CY 08, more than 33% of pregnant women eligible for Medicaid services received a dental service. This is increased from 32% for the last year. KOHP does not keep an active list of Medicaid dental providers but have a good relationship with the dental program in Medicaid that we could get that information when needed. The provider lists in Medicaid are changing continually and makes providing it to others futile, because as soon as the information it shared, it is outdated.

c. Plan for the Coming Year

/2010/ The Kentucky Oral Health Program will collaborate with the Kentucky Department for Public Health's Prenatal Program and Medicaid to provide materials and activities targeting both the public and private health care providers regarding the importance of optimal oral health during pregnancy and throughout one's lifetime. Included in this effort are:

-continued partnership with the University of Kentucky College of Dentistry and their work with the Centering Pregnancy With Smiles program and curriculum in the western part of the Commonwealth as well as its expansion to other areas of the state.

-through outreach activities, the Kentucky Oral Health Program will continue to encourage dental screening and needed oral care for pregnant women in the Commonwealth.

-through a unique opportunity with the University of Louisville's Medical School and Dental School, the Kentucky Oral Health Program will be developing a curriculum that will assist obstetricians in the importance of routine and comprehensive dental care in the pregnant patient as well as education and training for the dental professional in the safe and effective management and treatment of the pregnant patient during the prenatal months to optimize the chances of a successful delivery and healthy baby.

-continued dissemination of pertinent studies and educational material to a list serve of identified oral health contacts in the local health departments.

-Kentucky's Medicaid Program will continue to include full mouth debridement for pregnant beneficiaries as a covered service.

-the Oral Health Program continues to be a partner with the March of Dimes Prematurity Initiative. //2010//

E. Health Status Indicators

Introduction

Kentucky uses the Health Status Indicators for evaluation and monitoring of many of our MCH efforts. In providing information to the public, KY uses the HSI in combination with selected Healthy People (HP) 2010 goals to provide a context for the public to see how KY does in comparison to national goals. DPH adopted selected HP 2010 goals as Healthy Kentuckians 2010 goals in 2000, and recently has completed a Mid-Decade review and update of nearly 1000 measures and whether or not the state is making progress towards them. This is particularly useful during the legislative sessions, and does guide our direction in state public health efforts.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.7	9.1	9.1	9.1	8.8
Numerator	4877	5072	5270	5355	4832
Denominator	55779	55990	57929	58959	54634
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

Narrative:
/2010/ The rate of LBW is increasing with the rate of preterm birth. In our data analysis, the rate of VLBW infant births has had little change over the last decade. In order to address LBW and VLBW, we are working on a number of programs. The GIFTS (Giving Infants and Families Tobacco Free Starts) program has been implemented for nearly a year and half in nine eastern KY counties to provide smoking cessation counseling and education for pregnant women. Within the first year of the program, 23.1% of the 540 participants have quit smoking. Counseling includes education about the risks associated with smoking and exposure to secondhand smoke such as preterm birth and low birth weight.

Additional projects include preconception and interconception care within health departments utilizing the CLA. Currently, KY has two Fetal & Infant Mortality Review programs that are being developed and starting implementation. Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. Fetal and infant deaths from 24 weeks gestation through 1 year of age will be reviewed.
Local health department staff provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program which has proven to increase positive birth outcomes. All pregnant women receiving services at the local health department are screened at each visit for the use of alcohol, tobacco and drug use, as well as exposure to secondhand smoke, and educated about preterm birth, nutrition, weight gain, exercise and dental care.

An additional program that targets the prevention of preterm birth and low birth weight is the "Healthy Babies are Worth the Wait" Prematurity Prevention Partnership. Kentucky

was selected as the only state in the nation to partner with National March of Dimes and Johnson & Johnson Pediatric Institute in a $1.5 million initiative, "Healthy Babies are Worth the Wait" Prematurity Prevention Partnership, designed to prevent 'preventable' preterm births in targeted areas by utilizing evidence-based clinical and public health interventions with a goal to maximize all of the services in the community that can help lower the rates of preterm birth. Interventions include raising public awareness about preterm birth, provider education about new research information, patient safety strategies, and enhancing patient referrals to services in the community that improve birth outcomes. Other interventions include smoking cessation programs, physician accountability QI initiatives and education regarding scheduled and elective preterm deliveries, continued education to providers and pregnant women regarding oral health and the association of periodontal disease with pregnancy outcomes to name a few. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.1	7.3	7.5	7.6	7.3
Numerator	3760	3961	4145	4256	3873
Denominator	53271	54140	55226	56350	53001
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

Narrative:
/2010/ The rate of LBW is increasing with the rate of preterm birth. In our data analysis, the rate of VLBW infant births has had little change over the last decade. In order to address LBW and VLBW, we are working on a number of programs. The GIFTS (Giving Infants and Families Tobacco Free Starts) program has been implemented for nearly a year and half in nine eastern KY counties to provide smoking cessation counseling and education for pregnant women. Within the first year of the program, 23.1% of the 540 participants have quit smoking. Counseling includes education about the risks associated with smoking and exposure to secondhand smoke such as preterm birth and low birth weight.

Additional projects include preconception and interconception care within health departments utilizing the CLA. Currently, KY has two Fetal & Infant Mortality Review programs that are being developed and starting implementation. Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses,

monitors, and works to improve service systems and community resources for women, infants, and families. Fetal and infant deaths from 24 weeks gestation through 1 year of age will be reviewed.
Local health department staff provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program which has proven to increase positive birth outcomes. All pregnant women receiving services at the local health department are screened at each visit for the use of alcohol, tobacco and drug use, as well as exposure to secondhand smoke, and educated about preterm birth, nutrition, weight gain, exercise and dental care.

An additional program that targets the prevention of preterm birth and low birth weight is the "Healthy Babies are Worth the Wait" Prematurity Prevention Partnership. Kentucky was selected as the only state in the nation to partner with National March of Dimes and Johnson & Johnson Pediatric Institute in a $1.5 million initiative, "Healthy Babies are Worth the Wait" Prematurity Prevention Partnership, designed to prevent 'preventable' preterm births in targeted areas by utilizing evidence-based clinical and public health interventions with a goal to maximize all of the services in the community that can help lower the rates of preterm birth. Interventions include raising public awareness about preterm birth, provider education about new research information, patient safety strategies, and enhancing patient referrals to services in the community that improve birth outcomes. Other interventions include smoking cessation programs, physician accountability QI initiatives and education regarding scheduled and elective preterm deliveries, continued education to providers and pregnant women regarding oral health and the association of periodontal disease with pregnancy outcomes to name a few. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.7	1.6	1.7	1.6	1.4
Numerator	960	899	990	927	756
Denominator	55779	55990	57929	58959	54634
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

Narrative:
/2010/ The rate of LBW is increasing with the rate of preterm birth. In our data analysis, the rate of VLBW infant births has had little change over the last decade. In order to address

LBW and VLBW, we are working on a number of programs. The GIFTS (Giving Infants and Families Tobacco Free Starts) program has been implemented for nearly a year and half in nine eastern KY counties to provide smoking cessation counseling and education for pregnant women. Within the first year of the program, 23.1% of the 540 participants have quit smoking. Counseling includes education about the risks associated with smoking and exposure to secondhand smoke such as preterm birth and low birth weight.

Additional projects include preconception and interconception care within health departments utilizing the CLA. Currently, KY has two Fetal & Infant Mortality Review programs that are being developed and starting implementation. Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. Fetal and infant deaths from 24 weeks gestation through 1 year of age will be reviewed.
Local health department staff provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program which has proven to increase positive birth outcomes. All pregnant women receiving services at the local health department are screened at each visit for the use of alcohol, tobacco and drug use, as well as exposure to secondhand smoke, and educated about preterm birth, nutrition, weight gain, exercise and dental care.

An additional program that targets the prevention of preterm birth and low birth weight is the "Healthy Babies are Worth the Wait" Prematurity Prevention Partnership. Kentucky was selected as the only state in the nation to partner with National March of Dimes and Johnson & Johnson Pediatric Institute in a $1.5 million initiative, "Healthy Babies are Worth the Wait" Prematurity Prevention Partnership, designed to prevent 'preventable' preterm births in targeted areas by utilizing evidence-based clinical and public health interventions with a goal to maximize all of the services in the community that can help lower the rates of preterm birth. Interventions include raising public awareness about preterm birth, provider education about new research information, patient safety strategies, and enhancing patient referrals to services in the community that improve birth outcomes. Other interventions include smoking cessation programs, physician accountability QI initiatives and education regarding scheduled and elective preterm deliveries, continued education to providers and pregnant women regarding oral health and the association of periodontal disease with pregnancy outcomes to name a few. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.3	1.3	1.4	1.3	1.1
Numerator	715	681	770	742	593
Denominator	53271	54140	55226	56350	53001
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

Narrative:
/2010/ The rate of LBW is increasing with the rate of preterm birth. In our data analysis, the rate of VLBW infant births has had little change over the last decade. In order to address LBW and VLBW, we are working on a number of programs. The GIFTS (Giving Infants and Families Tobacco Free Starts) program has been implemented for nearly a year and half in nine eastern KY counties to provide smoking cessation counseling and education for pregnant women. Within the first year of the program, 23.1% of the 540 participants have quit smoking. Counseling includes education about the risks associated with smoking and exposure to secondhand smoke such as preterm birth and low birth weight.

Additional projects include preconception and interconception care within health departments utilizing the CLA. Currently, KY has two Fetal & Infant Mortality Review programs that are being developed and starting implementation. Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. Fetal and infant deaths from 24 weeks gestation through 1 year of age will be reviewed.
Local health department staff provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program which has proven to increase positive birth outcomes. All pregnant women receiving services at the local health department are screened at each visit for the use of alcohol, tobacco and drug use, as well as exposure to secondhand smoke, and educated about preterm birth, nutrition, weight gain, exercise and dental care.

An additional program that targets the prevention of preterm birth and low birth weight is the "Healthy Babies are Worth the Wait" Prematurity Prevention Partnership. Kentucky was selected as the only state in the nation to partner with National March of Dimes and Johnson & Johnson Pediatric Institute in a $1.5 million initiative, "Healthy Babies are Worth the Wait" Prematurity Prevention Partnership, designed to prevent 'preventable' preterm births in targeted areas by utilizing evidence-based clinical and public health interventions with a goal to maximize all of the services in the community that can help lower the rates of preterm birth. Interventions include raising public awareness about preterm birth, provider education about new research information, patient safety strategies, and enhancing patient referrals to services in the community that improve birth outcomes. Other interventions include smoking cessation programs, physician accountability QI initiatives and education regarding scheduled and elective preterm deliveries, continued education to providers and pregnant women regarding oral health and the association of periodontal disease with pregnancy outcomes to name a few. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Indicator	13.7	12.6	9.7	6.9	6.3
Numerator	113	104	80	57	52
Denominator	826377	823524	824209	828157	828157
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is preliminary and numbers could change.

2008 population estimates are currently not available therefore, the 2007 estimates were used for the denominator.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

Narrative:
/2010/ The state of Kentucky has seen a decrease in its death rate of unintentional injuries among children aged 14 years and younger. A strong influence for this improvement is the emphasis of Child Fatality Review and Injury Prevention in the Division. Working with Safe Kids Kentucky, the Kentucky Injury Prevention and Research Center, the National Violent Death Reporting System and partners of the like have strengthened our efforts immensely. Coalitions and review teams at the state level meet on a regular basis to discuss new strategies of prevention and general child safety issues. Much focus has been applied to increasing the number of local child fatality review teams and strengthening those already existing. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.1	5.0	4.6	2.5	2.7
Numerator	50	41	38	21	22
Denominator	826377	823524	828830	828157	828157
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is preliminary and numbers could change. 2008 population estimates are currently not available therefore, 2007 population estimates were used for the denominator.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

Narrative:
/2010/ While still considerably lower than years past, Kentucky's death rate of unintentional injuries among children aged 14 years and younger due to motor vehicle crashes did see a slight increase from 2007. In 2006 the rate was at 4.6 per 100,000, then showing a 50% decrease in the rate in 2007 when it dropped to 2.5 per 100,000. Currently 2.7 per 100,000 is the standing 2008 rate. Kentucky's decreased death rate in this area is due in part to the state's overall focus on vehicle safety. We have a recent primary seat belt law that has contributed to this decrease. But more focused on this age group is our new Booster Seat Bill. This bill is critical to the state of Kentucky. After seven years of advocacy by a number of groups, the Booster Seat Bill was passed in the 2008 Kentucky General Assembly. Booster seats will be required for children age seven and under and those between 40 and 50 inches in height when riding in a vehicle. Courtesy warnings were issued for the first year, with enforcement now beginning in July 2009. We hope to pursue raising the age to eight when the opportunity arises. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	42.9	37.5	33.4	26.7	23.7
Numerator	248	213	207	165	146
Denominator	577985	567982	619836	616889	616889
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is preliminary and numbers could change. 2008 population estimates are currenly not available therefore, 2007 population estimates were used for the denominator.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

Narrative:
/2010/ The death rate of unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years in Kentucky has shown a decrease for the 4th consecutive year. The current death rate is 23.7 per 100,000. These decreases can in part be due to the primary seat belt law that was recently passed. But also contributing to the decrease is the Graduated Driver's Licensing (GDL) law. This law, passed in 2006, aims at educating our youth on safe driving habits. These education efforts continue even today and include getting the word of GDL into schools and to parents. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	147.5	142.1	142.1	136.0	129.0
Numerator	1219	1174	1174	1126	1068
Denominator	826377	826015	826015	828157	828157
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data is preliminary and numbers could change.

2008 population estimates are currently not available therefore, 2007 estimates were used for the denominator.

Notes - 2007
2007 data is preliminary and numbers could change.

Notes - 2006
Data for this indicator is now being reported through the Kentucky Injury Prevention Research Center out of the University of Kentucky. This agency will be able to provide more accurate data as it relates to the area of injury. This agency receives data from hospitalization records only and currently does not have access to emergency room data. 2006 data is currently not available and figure reflects 2005 data.

Narrative:
/2010/ Kentucky's rate of unintentional injuries among children aged 14 years and younger due to motor vehicle crashes is lower than previous years. This decrease is due in part to the state's overall focus on vehicle safety. We have a recent primary seat belt law that has contributed to this decrease. But more focused on this age group is our new Booster Seat Bill. This bill is critical to the state of Kentucky. After seven years of advocacy by a number of groups, the Booster Seat Bill was passed in the 2008 Kentucky General Assembly. Booster seats will be required for children age seven and under and those between 40 and 50 inches in height when riding in a vehicle. Courtesy warnings were issued for the first year, with enforcement now beginning in July 2009. We hope to pursue raising the age to eight when the opportunity arises. Also contributing to the decrease is

the Graduated Driver's Licensing (GDL) law. This law, passed in 2006, aims at educating our youth on safe driving habits. These education efforts continue even today and include getting the word of GDL into schools and to parents. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	25.0	22.5	22.5	15.7	18.6
Numerator	207	186	186	130	154
Denominator	826377	826015	826015	828157	828157
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data is preliminary and numbers could change.

2008 population estimates are currently not available therefore, 2007 estimates were used for the denominator.

Notes - 2007
2007 data is preliminary and numbers could change.

Notes - 2006
Data for this indicator is now being reported through the Kentucky Injury Prevention Research Center out of the University of Kentucky. This agency will be able to provide more accurate data as it relates to the area of injury. This agency receives data from hospitalization records only and currently does not have access to emergency room data. 2006 data is currently not available and figure reflects 2005 data.

Narrative:
/2010/ The trend from 2004 to 2007 was a decline in the non-fatal injuries for children 14 and younger, but in 2008 we see a 19% increase as compared to 2007.

In addressing future non-fatal injuries Kentucky has passed the Booster Seat Bill. Booster seats will be required for children age seven and under and those between 40 and 50 inches in height when riding in a vehicle. Courtesy warnings were issued for the first year, with enforcement now beginning in July 2009. We hope to pursue raising the age to eight when the opportunity arises. Also contributing to the decrease is the Graduated Driver's Licensing (GDL) law. This law, passed in 2006, aims at educating our youth on safe driving habits. These education efforts continue even today and include getting the word of GDL into schools and to parents. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	153.1	141.6	141.6	125.2	110.9
Numerator	885	828	828	701	621
Denominator	577985	584540	584840	559766	559766
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data is preliminary and numbers could change.

2008 population estimates are currently not available, therefore, the 2007 estimates were used for the denominator.

Notes - 2007
2007 data is preliminary and numbers could change. The 2007 file is not complete as data from a few hospitals is missing. Health Policy does not anticipate having a complete file reflecting all hospitals until mid August. This years indicator will be updated next year to reflect appropriate numbers.

Notes - 2006
Data for this indicator is now being reported through the Kentucky Injury Prevention Research Center out of the University of Kentucky. This agency will be able to provide more accurate data as it relates to the area of injury. This agency receives data from hospitalization records only and currently does not have access to emergency room data. 2006 data is currently not available and figure reflects 2005 data.

Narrative:
/2010/ The rate of unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years in Kentucky has shown a consistent decrease in recent years. The current rate is 111 per 100,000 nonfatal injuries, showing the decline of 11% as compared to 2007. These decreases can in part be due to the primary seat belt law that was recently passed. But also contributing to the decrease is the Graduated Driver's Licensing (GDL) law. This law, passed in 2006, aims at educating our youth on safe driving habits. These education efforts continue even today and include getting the word of GDL into schools and to parents. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	19.7	18.2	18.6	17.7	25.3
Numerator	2619	2445	2528	2428	3471
Denominator	133128	134356	135840	137048	137048
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 population estimates are not currently available through the U.S. Census Bureau therefor, 2007 estimates are being used for 2008.

Reporting of cases from both private and public providers has improved and more reports are being received which accounts for the increased rate.

Data Source: KY Dep. for Public Health, Division of Epidemiology and Health Planning, Sexually Transmitted Diseases Branch, Surveillance Section.

Notes - 2006
The Infertility Prevention Program targets chlamydia screening to women ages 15-24 receiving family planning services. Women above age 24 are screened if they are at increased risk due to multiple sex partners, exposure to an infected partner or a prior history of a STD. All women who present to STD clinics in Kentucky are screened for chlamydia.

The amplified testing procedure that is currently utilized for chlamydia detection is far more sensitive than prior procedures. As a result, more positive results are being found, reported and treated.

The time span between specimen collection and treatment date is being monitored to ensure timely treatment of infected individuals and the reduction of spread of the disease.

Narrative:
/2010/ 05A The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.

Increases in Chlamydia

• Kentucky's Infertility Prevention Program targets Chlamydia screening to women of child bearing age. These is accomplished by providing routine screening to women receiving family planning services and are between the ages of 15-25. Chlamydia infection is a leading cause of infertility in women. All women who present to STD clinics are routinely screened for chlamydia.

• The amplified testing procedure that is currently utilized for Chlamydia detection is far more sensitive than prior procedures. As a result, more positive results are being found among persons tested. Consequently, increased reporting for Chlamydia has occurred.

• Testing and rapid treatment programs play an integral part in promoting reproductive health. The Kentucky STD program is currently monitoring the time span between specimen collection and treatment date to ensure timely treatment of infected individuals, which will stem the spread of disease and complications. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Indicator	4.7	4.7	4.8	4.9	6.7
Numerator	3514	3434	3542	3575	4873
Denominator	739968	735723	731707	728904	728904
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 population estimates are not currently available from the U.S. Census Bureau, therefore, 2007 estimates are being used.

Reporting of cases by private and public providers has improved as more reports are being received which accounts for the increase.

Data Source: KY Dep. for Public Health, Division of Epidemiology and Health Planning, Sexually Transmitted Diseases Branch, Surveillance Section.

Narrative:
/2010/ 05B The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia

•Women above the age of 25 who seek services in family planning clinics are screened for chlamydia if they are at increased risk, such as multiple sex partners, new sexual partner within the prior 60 days, exposure to an infected partner, or have symptoms. All women who present to STD clinics are routinely screened for chlamydia.
•The amplified testing procedure that is currently utilized for Chlamydia detection is far more sensitive than prior procedures. As a result, more positive results are being found among persons tested. Consequently, increased reporting for Chlamydia has occurred.
•Testing and rapid treatment programs play an integral part in promoting reproductive health. The Kentucky STD program is currently monitoring the time span between specimen collection and treatment date to ensure timely treatment of infected individuals, which will stem the spread of disease and complications. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	55409	47818	5643	125	641	28	1154	0
Children 1 through 4	222921	192345	21592	417	2922	95	5550	0
Children 5	274524	238563	25841	642	3010	128	6340	0

through 9								
Children 10 through 14	275303	240661	25877	639	2681	145	5300	0
Children 15 through 19	282187	246650	28680	716	2096	162	3883	0
Children 20 through 24	277579	243034	27646	936	2759	145	3059	0
Children 0 through 24	1387923	1209071	135279	3475	14109	703	25286	0

Notes - 2010

Narrative:
/2010/ Based upon the latest census data (2007), births in Kentucky total 58,959, which is a 1.7% increase from 2006. The African American population remains stable at about 7.7% of Kentucky's total population.

The Commission for Children with Special Health Care Needs reported the following distributions among its 8,862 enrollees: 78% white; 8.2% Black/African American; 4% Hispanic; 3% Other; less than 1% Asian, less than 1% Native American/Alaska native and less than 1% Native Hawaiian/Pacific Islander. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	52922	2487	0
Children 1 through 4	213073	9848	0
Children 5 through 9	265053	9471	0
Children 10 through 14	267625	7678	0
Children 15 through 19	275754	6433	0
Children 20 through 24	269751	7828	0
Children 0 through 24	1344178	43745	0

Notes - 2010

Narrative:
/2010/ Based on population estimates from 2007, the Hispanic population in Kentucky is 94,626, which is an increase of 9.2% from the previous year. Total Hispanic females in 2007 in Kentucky are estimated to be 40,895 and 1,189 are infants. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific**	**More than one race reported**	**Other and Unknown**

						Islander		
Women < 15	85	66	14	0	0	0	0	5
Women 15 through 17	2067	1669	301	2	5	0	0	90
Women 18 through 19	5263	4357	724	6	23	0	0	153
Women 20 through 34	42142	36149	3819	53	642	7	0	1472
Women 35 or older	5042	4308	380	4	163	0	0	187
Women of all ages	54599	46549	5238	65	833	7	0	1907

Notes - 2010

Narrative:
/2010/ At the local level, all health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits is being processed.

Local health department staff will continue to provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program which has shown to increase positive pregnancy outcomes. In addition, local health department staff will make an appointment or a referral for the pregnant woman for prenatal services, as well as assisting Medicaid eligible pregnant women to access services. Local health departments and communities will be encouraged to emphasize prematurity prevention and early entry into prenatal care through the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit.
The Kentucky Folic Acid Partnership (KFAP) began in September 1999 and has now expanded to 92 members representing 56 agencies/organizations and businesses. This organization is chaired by the Director of the Division of Maternal and Child Health, Department for Public Health. The KFAP encourages community activities to educate about the use of folic acid to prevent birth defects and has expanded their role to educate communities about preterm birth prevention.

Additionally, the Kentucky Office of Health Equity (OHE) was established in September 2008, functionally operating through the Kentucky Department of Public Health (KDPH), Commissioner's Office. The goals are to identify and establish collaborations to enhance health equity across the state of Kentucky, analyze data specific to health inequities across the state, develop strategies to address health inequities and improve health, and implement a project to eliminate infant mortality inequities.
Currently the infant mortality rate in Kentucky is 7.9/ 1000 live births. The African-American infant mortality rate in Kentucky is at 15.1/1000, while white infant rate is 7.6/1000. This disparity has widened since 2005. To address this disparity the Jefferson County Infant Mortality Project was developed in collaboration with the Center for Health Equity, based out of the Louisville Metro Department of Public Health and Wellness with the purpose to determine the socio-ecological influences/social determinants that lead to adverse pregnancy outcomes and infant mortality among African-American women in urban communities of Jefferson County. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	77	8	0
Women 15 through 17	1944	121	2
Women 18 through 19	5015	243	5
Women 20 through 34	39989	2131	22
Women 35 or older	4759	276	7
Women of all ages	51784	2779	36

Notes - 2010

Narrative:
/2010/ At the local level, all health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits is being processed.

Local health department staff will continue to provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program which has shown to increase positive pregnancy outcomes. In addition, local health department staff will make an appointment or a referral for the pregnant woman for prenatal services, as well as assisting Medicaid eligible pregnant women to access services. Local health departments and communities will be encouraged to emphasize prematurity prevention and early entry into prenatal care through the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit.
The Kentucky Folic Acid Partnership (KFAP) began in September 1999 and has now expanded to 92 members representing 56 agencies/organizations and businesses. This organization is chaired by the Director of the Division of Maternal and Child Health, Department for Public Health. The KFAP encourages community activities to educate about the use of folic acid to prevent birth defects and has expanded their role to educate communities about preterm birth prevention.

Additionally, the Kentucky Office of Health Equity (OHE) was established in September 2008, functionally operating through the Kentucky Department of Public Health (KDPH), Commissioner's Office. The goals are to identify and establish collaborations to enhance health equity across the state of Kentucky, analyze data specific to health inequities across the state, develop strategies to address health inequities and improve health, and implement a project to eliminate infant mortality inequities.
Currently the infant mortality rate in Kentucky is 7.9/ 1000 live births. The African-American infant mortality rate in Kentucky is at 15.1/1000, while white infant rate is 7.6/1000. This disparity has widened since 2005. To address this disparity the Jefferson County Infant Mortality Project was developed in collaboration with the Center for Health Equity, based out of the Louisville Metro Department of Public Health and Wellness with

the purpose to determine the socio-ecological influences/social determinants that lead to adverse pregnancy outcomes and infant mortality among African-American women in urban communities of Jefferson County. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	315	255	52	0	5	0	0	3
Children 1 through 4	50	46	3	0	1	0	0	0
Children 5 through 9	36	33	3	0	0	0	0	0
Children 10 through 14	49	45	3	0	0	0	0	1
Children 15 through 19	156	139	15	0	0	0	0	2
Children 20 through 24	243	215	24	0	3	0	0	1
Children 0 through 24	849	733	100	0	9	0	0	7

Notes - 2010

Narrative:
/2010/ The infant mortality rate in Kentucky is 7.9/1000 live births, with the rate of African-American infant mortality rate at 15.1/1000 and the white infant mortality rate at 7.6/1000. This disparity has widened since 2005.

Addressing this issue includes the development of the Jefferson County Infant Mortality Project, in conjunction with the Center for Health Equity based at the Louisville Metro Department of Public Health and Wellness. This project determines the socio-ecological influences/social determinants that lead to adverse pregnancy outcomes and infant mortality among African-American Women in the Jefferson County communities. Also, the Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. Fetal and infant deaths from 24 weeks gestation through 1 year of age are reviewed.

Review of deaths of older children is conducted by the state and local Child Fatality Review committees. All deaths are reviewed for identification of causes of death in order to determine prevention strategies. Also, in collaboration with the University of Kentucky, the Kentucky Injury Prevention Research Center facilitates, develops policy, gathers and analyzes data to identify trends, patterns and risks, provides technical assistance and training, while also reviewing data provided by the Child Fatality Review committees. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	294	18	3
Children 1 through 4	46	4	0
Children 5 through 9	34	2	0
Children 10 through 14	47	1	1
Children 15 through 19	149	6	1
Children 20 through 24	226	16	1
Children 0 through 24	796	47	6

Notes - 2010

Narrative:
/2010/ As of 2008, the preliminary rate of infant mortality for the Hispanic population is 6.5/1000 live births.

Addressing this issue includes the development of the Jefferson County Infant Mortality Project, in conjunction with the Center for Health Equity based at the Louisville Metro Department of Public Health and Wellness. This project determines the socio-ecological influences/social determinants that lead to adverse pregnancy outcomes and infant mortality among African-American Women in the Jefferson County communities. Also, the Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. Fetal and infant deaths from 24 weeks gestation through 1 year of age are reviewed.

Review of deaths of older children is conducted by the state and local Child Fatality Review committees. All deaths are reviewed for identification of causes of death in order to determine prevention strategies. Also, in collaboration with the University of Kentucky, the Kentucky Injury Prevention Research Center facilitates, develops policy, gathers and analyzes data to identify trends, patterns and risks, provides technical assistance and training, while also reviewing data provided by the Child Fatality Review committees. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1110344	966037	107633	2539	11350	558	22227	0	2008
Percent in household	33.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2007

headed by single parent									
Percent in TANF (Grant) families	10.6	7.8	2.6	0.3	0.4	0.2	0.5	0.0	2008
Number enrolled in Medicaid	432056	339536	64461	1333	2173	639	1270	22644	2008
Number enrolled in SCHIP	69960	61753	7404	177	409	77	104	36	2008
Number living in foster home care	7212	5310	1381	14	7	12	0	488	2008
Number enrolled in food stamp program	936630	788244	136586	2007	3787	1220	1753	3033	2008
Number enrolled in WIC	140488	121263	16503	276	836	1609	0	1	2008
Rate (per 100,000) of juvenile crime arrests	58.7	45.9	151.0	29.5	10.2	15.4	97.5	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	3.3	2.9	6.1	4.3	1.8	0.0	0.0	4.1	2008

Notes - 2010
Data is per 10,000 sepcified population.

Narrative:
/2010/ The total of all children in Kentucky, ages 0 through 19 years of age, in miscellaneous situations or enrolled in various State programs is increased by 25% from 2007.

The percent in household headed by single parent remains stable for 2008 from previous years, with no differentiation between race reported.

The percent in TANF (Grant) families is decreased less than 1% from 2007.

The number enrolled in Medicaid has decreased from 2007, by 40%. Education and awareness of Medicaid eligibility and enrollment is being increased through efforts of local health departments throughout the state.

The number enrolled in SCHIP is significantly increased from 2007. Figures may be the result of a change in counting and reporting enrollment cases. However enrollment in KCHIP is expected to increase due to a statewide KCHIP enrollment initiative, effective November 1, 2008, and the roll out of a mail-in application process to remove barriers to enrollment.

The number living in foster home care shows a slight decrease of 3.5% from 2007.

The number enrolled in food stamp program has significantly increased by 274% from 2007 and may be contributed to the decline of the economy, with loss of jobs and increasing food prices.

The number enrolled in WIC has shown an increase of 10.5%, attributable again to the declining economy, job losses and increasing food prices.

The rate (per 100,000) of juvenile crime arrests is increased 55% from 2007.

The percentage of high school drop-outs (grade 9 through 12) has increased slightly at less than 1%. The Kentucky Board of Education has increased its attention and focus concerning the high school drop-out rates in Kentucky. The Kentucky Department of Education (KDE) has dedicated efforts across all programs (in everything that they do) to address drop-out issues which includes the provision of guidance, technical assistance, professional development and drop-out prevention grants to schools. In February 2009 America's Promise Alliance partnering with the KDE offered a Drop-Out Prevention Summit in Eastern Kentucky, Mt. Sterling. This Summit brought together the schools, businesses and local community to learn more about this issue which included keynote speaker John Bridgeland of the "The Silent Epidemic". First Lady Jane Beshear will be hosting "Graduate Kentucky: A Community Approach" which will be a state-wide drop-out prevention summit in September 2009.
//2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1074427	35917	0	2007
Percent in household headed by single parent	0.0	0.0	33.0	2007
Percent in TANF (Grant) families	10.2	0.4	0.0	2008
Number enrolled in Medicaid	414718	17338	0	2008
Number enrolled in SCHIP	67406	2554	0	2008
Number living in foster home care	6923	289	199	2008
Number enrolled in food stamp program	904706	28891	3033	2008
Number enrolled in WIC	128483	12005	0	2008
Rate (per 100,000) of juvenile crime arrests	68.8	34.8	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	6.1	0.0	2008

Notes - 2010
Data is per 10,000 specified population.

Narrative:
/2010/ The total of all children in Kentucky, ages 0 through 19 years of age, in miscellaneous situations or enrolled in various State programs is increased by 25% from

2007.

The percent in household headed by single parent remains stable for 2008 from previous years, with no differentiation between race reported.

The percent in TANF (Grant) families is decreased less than 1% from 2007.

The number enrolled in Medicaid has decreased from 2007, by 40%. Education and awareness of Medicaid eligibility and enrollment is being increased through efforts of local health departments throughout the state.

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//2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	655619
Living in urban areas	619402
Living in rural areas	509104
Living in frontier areas	0
Total - all children 0 through 19	1128506

Notes - 2010

Narrative:
/2010/ Children aged 0-19 made up 26.2% of the total population in Kentucky in 2007. As births continue to increase in KY so does this particular age group. The geographic make-up of Kentucky is somewhat diverse ranging from plain fields in the west to mountainous regions in the east along with coal fields, farmland, and urban cities in between. Although Kentucky is mainly considered a "rural" state, a majority of children aged 0-19 (45.1%) live in areas classified as rural. Well over half of these children (54.9%) live in areas classified as urban and 58.1% living in metro areas, mainly the Louisville/Jefferson county region. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	4241474.0
Percent Below: 50% of poverty	7.4
100% of poverty	15.5
200% of poverty	38.2

Notes - 2010

Narrative:
/2010/ The Median household income in Kentucky from 2007 has increased to $40,299, up from $37,369 in 2005. The estimated median household in the United States is $50,007, based upon 2005-2007 figures. The county with the greatest poverty level is Owsley, situated in the Eastern Coal Field Region. Owsley is one of four of Kentucky's 120 counties designated as one of the Federal Renewal Communities by the US Department of Housing and Urban Development. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1074427.0
Percent Below: 50% of poverty	11.8
100% of poverty	21.0
200% of poverty	43.2

Notes - 2010

Narrative:
/2010/ There is a steady increase in Kentucky's total population under age 18 living in poverty. The 2007 figure of 23.6% is increased from 20.2% (1999). The highest population of children living in poverty is 55.0% in Owsley County, the county of the greatest poverty level within the state. //2010//

F. Other Program Activities

Sexual Assault Prevention Program

Kentucky's first Rape Crisis Center began serving victims of rape and sexual assault in 1971. Today, 13 regional Rape Crisis Centers (RCCs) in Kentucky provide an array of sexual assault services to victims, their family members and friends. In addition to providing victim services, the RCCs provide an array of training and educational services throughout the state focused on risk reduction and awareness. The RCCs and their coalition, the Kentucky Association of Sexual Assault Programs (KASAP), have continued to honor the Cooperative Agreement with the Center for Disease Control and Prevention, Division of Violence Prevention that began in the fall of 2006.

The Sexual Violence Prevention Education (SVPE) funds (formerly known as the Rape Prevention and Education Program), have begun to incorporate primary prevention efforts aimed at ending the perpetration and victimization of sexual assault into their education programming. Efforts in the second year of this Cooperative Agreement have included the support of the Statewide Sexual Violence Prevention Planning Team (SVPT), a subcommittee of the Cabinet for Health and Family Services', Council on Domestic Violence and Sexual Assault. The SVPT has continued its comprehensive planning process based on the principles of Empowerment Evaluation and the 10 steps of Getting to Outcomes. Facilitated by the Statewide Capacity Building Team (SCBT) made up of the Cooperative Agreement coordinator, the Executive Director of KASAP, and Empowerment Evaluator from the University of Kentucky School of Social Work, the SVPT has collected and analyzed statewide data related to rape and sexual assault.

The result of this process was the establishment of draft target populations for the primary prevention focus of the participating RCCs. The following draft target populations were identified and will be further vetted for final selection: college-age persons (ages 18 -- 24), middle/high school persons (ages 11 -- 17), at risk families with children ages 4 -- 6), substance abusers and rural unreachables in economic distress. The establishment of further goals and objectives are also underway.

Funding from this Cooperative Agreement supports the continuation of the SVPT; supports the SCBT who continue to participate in the EMPOWER Cooperative Agreement with the CDC, Division of Violence Prevention; continues the training and technical assistance component being given to RCCs; and supports the establishment of an evaluation component which will include a plan for long term surveillance activities.

In addition to implementing a comprehensive planning component with this Cooperative Agreement, Kentucky's 13 RCCs and KASAP also continue to conduct the legislatively approved activities as a part of its comprehensive statewide SVPE Program with the emphasis on strategies that include primary prevention efforts.

The Department for Public Health is currently collaborating with Dr. Ann Coker to identify and secure funding and resources on Domestic Violence and Women's Health issues. Dr. Coker is the Professor and Verizon Wireless Endowed Chair in the Center for Research on Violence against Women at the University of Kentucky.

/2010/
Childhood Lead Poisoning Prevention Program

Core Mission:

The Childhood Lead Poisoning Prevention Program (CLPPP) assures case management, education and seeks to eliminate childhood elevated blood lead levels and poisoning in

KY. CLPPP focuses efforts on increased screening of high risk populations, education, environmental remediation and primary prevention activities to eliminate childhood lead poisoning as a public health problem. The goals of the program are to increase the number of children under the age of 6 years of age that receive blood lead tests, and to increase the number of primary prevention activities occurring statewide, placing special emphasis on targeted screening areas known to be high risk for lead poisoning. A targeted screening plan has been developed and is being disseminated to providers across the state to identify high risk areas where children should be screened.

All Kentucky labs are required to report elevated lead levels to DPH. Children identified with levels >15 are followed by case managers at the local health department until issues of potential toxicity and environmental source have been resolved. Currently there are some 300 children in case management.

Vital Statistics:

All Medicaid eligible children should receive a lead screening at 12 and 24 months and at 72 months or under if they have not been previously screened. Children living in targeted zip code areas or that answer "yes" or "don't know" to during a Verbal Risk Assessment also receive lead screenings. In 2008 approximately 30,853 children 0-6 years of age were screened and referred to appropriate services.

Budget:

KY Childhood Lead Poisoning Prevention Program received federal funding of $562,575.00 from the Centers for Disease Control and Prevention (CDC) through a Lead Poisoning Prevention Grant.

Key Stakeholders:

Numerous partnerships at the state and local levels work together to build the infrastructure for the KY CLPPP:
This includes but is not limited to:
1. Cabinet for Health and Family Services: KY Department for Public Health: Division of Adult and Child Health: Maternal and Child Health Branch: WIC, QI/QA Team, Healthy Start, HANDS, Prenatal, Environmental Lead
2. KY CLPPP Advisory Committee made up of a broad base of stakeholders including parents of children with elevated blood lead levels, faith based organizations, the environmental lead program, and others
3. Kentucky Medical Association
4. Kentucky Department of Medicaid Services
5. Local Health Departments, physician's offices, hospital labs and laboratories

Emerging Issues:

Regulations are currently being revised (902 KAR 4:090) to include mandatory electronic reporting of laboratory testing.
Identify and acquire funding for a new lead poisoning surveillance system; CDC funding has been threatened and may not be recurring.
Provide information outlining targeted screening to physician's offices throughout KY to promote lead screening for at risk children.
Need to acquire a better data system for surveillance and case management; CDC working on a product they plan to have available by the end of the year. //2010//

/2010/ Substance Exposed Infant

Approximately 6,500 children are born in Kentucky each year that has been prenatally exposed to alcohol and other drugs. The problems these infants will likely encounter include developmental delays, difficulties with school readiness, mental health problems, behavioral issues, and poor health outcomes.

A special report was recently published by the National Center on Substance Abuse and Child Welfare entitled Substance Exposed Infants: State Response to the Problem. Interest in this report within the Division of Mental Health and Substance Abuse has resulted in the initiation of a statewide, inter-departmental workgroup. The workgroup sees its purpose as building collaborative capacity to reduce the incidence of substance exposure during pregnancy, protect children from harm, and improve the functioning of families and those children who have been prenatally exposed to substances. The report of the Substance Exposed Infants identifies four key intervention points:
•Pre-pregnancy
•During pregnancy
•At birth
•Postnatal through childhood and adolescence

Based on recommendations in the report and the work already done by Kentucky's Substance Abuse and Pregnancy Workgroup, the following general goals for the SEI workgroup have been drafted:
•Build relationships across agencies already serving this population
•Improve identification of substance exposed infants
•Streamline cross-referral processes
•Take stock of the services that are already in place
•Identify gaps in services
•Develop policies, protocols, collaborative agreements, projects, etc., that address the needs

The following agencies have been represented:
•Department for Public Health
•Department of Mental Health, Intellectual Disabilities, and Addiction Services (Children's Mental Health, Substance Abuse Treatment and Prevention, Developmental Disabilities)
•Department of Education (Early Childhood Development)
•Department for Community Based Services (Protection and Permanency, Child Care, START)
•Administrative Office of the Courts
•University of Kentucky (Pediatrics, Children's Hospital, and Center on Drug and Alcohol Research)
•Kentucky Partnership for Families and Children //2010//

G. Technical Assistance

Request assistance to support state staff and one parent representative traveling to AMCHP and for state staff traveling to MCHB mandatory meetings. The Commission also requests funding to support a consultation from staff of the Healthy and Ready to Work National Center for the leadership team that is designing the Building Linkages to Transition (BLT) project.

Kentucky requests on-going technical assistance with the Needs Assessment process and analysis. This will begin to build capacity and the skill sets necessary to conduct a comprehensive needs assessment.

Request continued technical assistance and consultation with the development and sustainability of a State FIMR project including assistance with training and facilitation of local FIMR projects.

/2010/ Kentucky requests technical assistance in analyzing and addressing the upward

trend in teenage pregnancy. The state's rate has consistently increased since 2005. The Title V Needs Assessment process has identified teen pregnancy as one of top three issues of concern, both from state-wide forums (conducted in March-May of 2009), as well as from consumer/patient surveys being received currently (>3,000). So we are in a position that Kentucky has a great deal of data, which we now will need to translate into actions at the community and state level. We seek technical assistance for developing a plan that will assist us in using our data, exploring evidence based approaches, coordinating existing resources, and finding new ideas to implement to address teen pregnancy. The Guttmacher Institute is nationally known for its work in teen pregnancy and has long been a resource that we have used in our Title X program. We would anticipate they would have the expertise to help us map out an action plan.

During the 2009 plan review, it was recommended that Kentucky request technical assistance to improve the state approach to addressing cultural competence. This would include improving services to populations with low literacy, limited English proficiency, and special needs, as well as racial and ethnic groups. The Commission for Children with Special Healthcare Needs (CCSHCN) in particular requests assistance due to the overall and growing need to work with families who are limited in English proficiency and their increasing focus on transitional issues (including health literacy) for all children and youth, and family-to-family collaboration. Although the Commission follows guidelines as set forth by the Language Access Section of the Office of Human Resource Management, and they are a s small group who do a great job at providing resources for persons who are limited in English proficiency and Spanish, they are not staffed to handle other languages or other cultural issues such as health literacy or rural culture. The National Center on Cultural Competence provides a number of tools for addressing cultural competence, so we would like to seek their assistance in evaluation of our programs and initiatives and ways we can integrate and improve cultural competence throughout.

It was also recommended during the 2009 plan review that Kentucky, including the CCSHCN, request technical assistance for meeting the needs of the deaf and blind populations in order to provide the resources and skill to make informed decisions about health and healthcare in order to move away from dependency. //2010//

V. Budget Narrative

A. Expenditures

Budget projections for this section are completed before the state fiscal year actually closes. Budgets for various activities should be considered "point-in-time" estimates however, staff completing this portion of the Title V provide as accurate information as is possible at that time.

Actual expenditures may also be different than budget because of carryover and the varience of grant years. The state fiscal year begins on July 1st and ends June 30th. The federal grant year (Title V) begins October 1st and ends September 30th. Many department grants have yet other timeframes.

Generally speaking, budgeted and actual expended dollars have been relatively consistant within a given year. Any notes to explain variences have been attached to the financial form which they address.

For this reason, questions regarding specific financial activites should be relayed to the the Department for Public Health, Division for Administration and Finance; the Division responsible for financial reporting.

/2010/ Kentucky has a constitutional amendment requiring a balanced budget at the end of each fiscal year. In the current economic climate, this will be challenging. //2010//

B. Budget

Budget projections for this section are completed before the state fiscal year actually closes. Budgets for various activities should be considered "point-in-time" estimates however, staff completing this portion of the Title V provide as accurate information as is possible at that time.

Actual expenditures may also be different then budget because of carryover and the variance of grant years. The state fiscal year begins on July 1st and ends June 30th. The federal grant year (Title V) begins October 1st and ends September 30th. Many department grants have yet other timeframes.

Generally speaking, budgeted and actual expended dollars have been relatively consistent within a given year. Any notes to explain variances have been attached to the financial form which they address.

For this reason, questions regarding specific financial activities should be relayed to the Department for Public Health, Division for Administration and Finance; the Division responsible for financial reporting.

Both the Division of Adult and Child Health Improvement and the Commission for Children with Special Health Care Needs will discuss FY06 budget within the section.

Division of Adult and Child Health Improvement, Department for Public Health

The vast majority of Title V Block Grant funding is allocated by the Division of Adult and Child Health Improvement to local health departments to support community programs that work toward attaining MCH performance and outcome measures.

In addition to MCH Title V funding, revenue from several major sources including other federal grants, KIDS NOW Early Childhood Initiative, KCHIP and Bioterrorism support local health

departments.

Based upon the current estimated block grant allocations to Kentucky in FY06, (total of $11,890,984) 34.9% or $4,149,953 will be contracted through a memorandum of agreement with the Commission for Children with Special Health Care Needs and the remainder of $7,741,031 will remain with the Department for Public Health.

For FY 06, the majority of this funding (93% or $7,234,570) will be re-allocated through a block grant process to local health departments. Local health departments have the ability to select particular cost centers in which to use this funding. Additionally, they may use it for clinical (personal health) or community (population-based) services.

Clinical service include well-child, maternity and prenatal care, family planning, oral health and nutrition services. Approximately 90% of Title V funding is used to cover local health department clinical services.

Community Services implemented by local health departments include prenatal classes, oral health classes, physical activity campaigns in schools, teen pregnancy prevention programs, injury prevention activities and smoking cessation campaigns; just to name a few. Approximately 10% of Title V funding is used to cover community services.

Special emphasis has been placed upon physical activity and nutrition services for youth. The combined use of all of the Preventive Services Block Grant and a portion of the Title V MCH Block grant is allocated solely to underwrite activities addressing the issue of inappropriate weight for height in Kentucky in children. As this performance measure is a primary health concern Kentucky's population, a combined use of these funds supports the intent of the block grant process; funding flexibility to address unique needs of states and communities.

In FY 05 funding to support prenatal care was designated for each county and health district; particularly for the uninsured and disparate populations. Program staff estimated that the costs of an uninsured birth are approximately $2,000 each. Hence, this sum was used to calculate allocations for Kentucky counties based upon historic needs. /2007/ This formula continues to be used for FY 06. //2007//

Below is a listing of how Kentucky's local health departments are using Title V funding during FY05. This is a projection based on program plans submitted by the local health departments, reviewed and approved by program staff.

(CC 712)Dental Clinical Services $4,316 (<1%)
(CC 800)Pediatric Well-Child $2,367,955 (31%)
(CC 802)Family Planning $1,259,505 (16.5%)
(CC 803)Maternity $1,338,835 (17.6%)
(CC 805)Nutrition $1,627,115 (21.4%)
(CC 852)Resource Persons $1,334 (<1%)
(CC 818)Community Activities $867,064 (11.4%)
(CC 857)Physical Activity $152,867 (2%)

Total $7,618,991

Local health department allocations are based on a formula that takes into account population and need on a county-by-county basis. Funds are provided for clinical and community health and while certain programs are required (such as family planning, prenatal, child preventative, adult personal health and medical nutrition therapy), allocations for individuals programs may vary depending upon community need as determined by a local needs assessment process. Throughout this process, MCH Title V funds must be used to meet MCH performance measures and applicable 2010 health objectives. The Title V Administrator works with the budget review

team who read each local health department plan and verify the proper use of MCH funding as well as the effectiveness of planned activities.

The Commission for Children with Special Health Care Needs receives 34.9% of the Title V Allocation which, in FY06, will amount to $4,149,953.

Additionally, capacity building costs for ACHI underwritten with Title V Funding include portions of two program contracts (Maternal Mortality Review and Public Health Training) with the University of Louisville. Funding has also been allocated in FY 06 to continue to support the Mental Health/Mental Retardation Suicide Prevention personnel($30,000). A new project is the Infant Mortality Project in Louisville Metro ($20,000).

Finally, some infrastructure costs for the Department for Public Health are underwritten by Kentucky's Title V Block Grant. This included a portion of the cost of Kentucky's local health department billing and services reporting system, Patient Service Record System (PSRS).

/2007/ Based upon the current estimated block grant allocations to Kentucky in FY07, (total of $11,496,808) 34.9% or $4,012,386 will be contracted through a memorandum of agreement with the Commission for Children with Special Health Care Needs and the remainder of $7,484,422 will remain with the Division of Adult and Child Health Improvement.

For FY 07, the majority of this funding (91% or $6,823,304) will be re-allocated through a block grant process to local health departments. Local health departments have the ability to select particular cost centers in which to use this funding. Additionally, they may use it for clinical (personal health) or community (population-based) services. Approximately 14% of Title V funding was used to cover community activities in FY 06.

Below is a listing of how Kentucky's local health departments are using Title V funding during FY06. This is a projection based on program plans submitted by the local health departments, reviewed and approved by program staff.

(CC 712)Dental Clinical Services $10,918 (<1%)
(CC 800)Pediatric Well-Child $1,725,817 (24%)
(CC 802)Family Planning $1,758,421 (24.3%)
(CC 803)Maternity $1,182,248 (16.3%)
(CC 805)Nutrition $1,083,775 (15%)
(CC 852)Resource Persons $575 (<1%)
(CC 818)Community Activities $990,413 (13.7%)
(CC 857)Physical Activity $482,403 (6.7%)

Total $7,234,570

Additionally, capacity building costs for DPH underwritten with Title V Funding include portions of two program contracts (Maternal Mortality Review and Public Health Training) with the University of Louisville that will continue in FY 07. Funding has also been reallocated in FY 07 to continue to support the Mental Health/Mental Retardation Suicide Prevention personnel ($30,000). The infant Mortality Project in Louisville is now being funded with State General Funds. //2007//

/2008/ Below is a listing of how Kentucky's local health departments are using Title V funding during FY07. This is a projection based on program plans submitted by the local health departments, reviewed and approved by program staff.

(CC 712) Dental Clinical Services $64,529 (1%)
(CC 800) Pediatric Well-Child $1,918,725 (28.2%)
(CC 802) Family Planning $1,665,051 (24.4%)
(CC 803) Maternity $1,120,394 (16.4%)

(CC 805) Nutrition $1,009,349 (14.8%)
(CC 818) Community Activities $695,839 (10.2%)
(CC 857) Physical Activity $334,676 (4.9%)

Total $6,808,563

Additionally, capacity building costs for DPH underwritten with Title V Funding include portions of two program contracts (Maternal Mortality Review and Public Health Pediatric Training) with the University of Louisville that will continue in FY 08. Fetal and Infant Mortality Review is being added to this contract to develop a statewide FIMR project. Funding has also been reallocated in FY 08 to continue to support the Mental Health/Mental Retardation Suicide Prevention personnel ($15,000). This contract was reduced when the Department of Mental Health Mental Retardation received a $400,000 grant for Youth Suicide Prevention.

For the KIDS NOW Early Childhood Programs funded through the Department of Education Tobacco Settlement Funds for FY 08.

Name	Amount
HANDS	$10,000,426
Reach Out and Read	$250,000
Healthy Start in Child Care	$1,180,719
Immunization for Underinsured	$2,017,950
Folic Acid	$424,366
Early Childhood Mental Health	$882,511
Early Childhood Oral Health	$377,018
KEIS	$1,000,000
TOTAL:	$16,132,990

//2008//

/2009/ Due to a delay in state budget allocations, the local health department plan and budget process was not complete at the time of grant submission. Thirty-four percent of Title V funding will be allocated to the Commission for Children with Special Health Care Needs. The remaining funds will remain with the Department for Public Health. The majority of the remaining funding will be used for allocations to local health departments for clinical and community services including Oral Health, Pediatric/Well Child Services, Family Planning, Maternity Services, Medical Nutrition Therapy, Physical Activity and Health Education. Other funding will Suicide Prevention, Fetal and Infant Mortality Review, Maternal Mortality Review, Pediatric Clinical training, CDP Billing and Reporting system, Title V staff and travel. //2009//
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Commission for Children with Special Health Care Needs

The Commission anticipates the FY05 budget to include state and agency funds in excess of the 1989 maintenance of effort level. State and agency funding is expected to remain above the 1989 maintenance of effort level of $8,170,428 for the foreseeable future.

In addition to MCH Title V Block grant dollars, the Commission's primary source of funding are State dollars (mix of state general funds and Tobacco Settlement funds) and Agency funds. The agency revenues are receipts from third party billings for direct patient care and care coordination. The Commissions' budget for FY05 is projected as follows: State General funds $6,205,000, Tobacco Settlement Funds $555,000, and Agency Funds $4,890,100. Other Federal sources of funding in the FY05 budget include CDC grant/University of North Carolina ($66,000); MCHB/Wake Forest University ($40,000); Sound Start (EHDI) Grant $126,000.

/2008/ FY08 includes Tobacco Settlement Funds $352,000, Agency Funds $4,008,100, CDC grant $67,000, and KISS grant $125,000. //2008//

/2009/ The fiscal condition the Commonwealth of Kentucky faces over the next two years is unprecedented, with projected revenues in both years of the next biennium significantly below current spending levels. To address the structural imbalance state agencies were required to reduce state funding. The Commission for Children with Special Health Care Needs reduced state and agency funds by 3% for fiscal year 2008. The budget for the biennium 2009-2010 required additional budget reductions. Key components to reducing operating expenses on a reduced budget base include:

•Reduction of state workforce through attrition. All hiring actions must be justified as essential to the delivery of services and that funds are available to sustain the position within the reduced budget.

•Review All Contracts for Cost Savings. All new contracts must be justified as essential to the delivery of services and must demonstrate that the service cannot be provided with existing personnel.

•Reduce Travel Expenses.

•Reduce printing Costs.

•Curtail Equipment and Furniture Purchases. A moratorium is placed on all purchases of furniture and equipment by state agencies.

Summary

While the budget for the state is austere, the budget for the Commission will be sufficient to continue services at current levels. This is far better than most state agencies; however it will require the Commission to operate on a bare bones budget. The Commission will be slow in filling positions, and all vacancies will need to be strongly justified. All expenses, from office supplies to furniture to equipment, will need to be justified. This will not be an easy time, but one that (barring a big downturn in the economy or some other statewide fiscal crisis) we should be able to continue services without interruption. //2009//

/2010/ The Commission's FY09 budget does include state and agency funds in excess of the maintenance of effort level. State and agency funding is expected to remain above the maintenance of effort level of $8,170,428 for the foreseeable future.

In addition to MCH Title V Block grant dollars, the Commission's primary sources of funding are State dollars (mix of state General Funds and Tobacco Settlement funds) and Agency Funds. The agency revenues are receipts from third party billings for direct patient care and care coordination, as well as family participation of fees based on income levels. The Commission's budget for FY09 is as follows: State General funds $5,425,500, Tobacco Settlement Funds $352,000, and Agency Funds $6,204,900. Other Federal sources of funding in the FY09 budget include CDC Grant/University of North Carolina ($62,236); MCHB/University of North Carolina ($38,382); EHDI Initiative ($150,882) and KISS Grant ($162,654).

The financial conditions faced by the Commonwealth of Kentucky since the last reporting period is unprecedented; with projected revenues that continue to be significantly below current spending levels. To address the structural imbalance, state agencies were required to reduce state funding for State Fiscal Year 2009 by over 5%, and expectations are that the Commission for Children with Special Health Care Needs will have the additional reductions in General Funds during FY10. To address the decrease in

revenues, the budget for the biennium 2009-2010 required budget reductions. Key components to reducing operating expenses on a reduced budget base include:

•Reduction of state workforce through attrition. All hiring actions must be justified as essential to the delivery of services and verify that funds are available to sustain the position within the reduced budget.

•Review All Contracts for Cost Savings. All new contracts must be justified as essential to the delivery of services and must demonstrate that the service cannot be provided with existing personnel.

•Reduce Travel Expenses.

•Reduce Printing Costs.

•Curtail Equipment and Furniture Purchases.

Summary

While the budget for the state is austere, the budget for the Commission will be sufficient to continue services at current levels. This is far better than most state agencies; however, it will require the Commission to operate on a bare bones budget, as well as act creatively with operations going forward to maximize potential savings. The Commission will be judicious in filling positions, and all vacancies will need to be scrutinized for their necessity to operational initiatives planned in order to maximize savings. All expenses, from office supplies to furniture to equipment, will need to be justified. While this is not an easy fiscal environment in which to operate, barring a drastically larger than anticipated downturn in the economy or some other statewide financial crisis, we should be able to continue services without an impact on the quality of care the Commission historically has provided to its patient population.

Based upon current allocations to Kentucky, the Title V Funding for FY 09 is as follow:

Cost Center	Description	FY 09
712	Dental Clinical Services	$365,109
800	Pediatric Well-Child	$2,944,056
802	Family Planning	$647,263
803	Maternity	$1,010,193
805	Nutrition	$1,017,943
818	Community Activities	$384,836
835	Pregnancy Smoking Cessation	$135,000
852	Resource Persons	$ -
857	Physical Activity	$93,167
	Total	$6,597,567 //2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.